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the Wisconsin Medical Journal

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A Monthly Journal of Medicine and Surgery

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VOLUME 63
JANUARY 1964–DECEMBER 1964

Wisconsin Medical Journal

ESTABLISHED 1903

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The Wisconsin Medical Journal, Official Publication
Advertising Representatives: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn St., Chicago, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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Journal
Established 1903
Annual Subscription-------$6.00
Single Copy---------- 1.00
Previous Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.

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Stanley L. Betts, Lincoln County, transferred to California.
Irvin L. Blose, Eau Claire–Dunn–Pepin County.
Christo Christoff, Milwaukee County, resigned.
Joyce M. Eisenbraun, Milwaukee County, resigned.
Robert S. Gearhart, Dane County, transferred to Arizona.
Paul R. Glunz, Milwaukee County, resigned.
Robert Gregor, Waukesha County.
E. F. Jorgensen, Clark County.
Philip B. Jorgensen, Clark County.
Marvin G. Jumes, Dane County, transferred to Oregon.
Max F. Lindquist, Eau Claire–Dunn–Pepin County, transferred to Minnesota.
William A. McClellan, Milwaukee County, transferred to Georgia.
Desmond McNelis, Milwaukee County, transferred to Maryland.
R. C. Meade, Milwaukee County, resigned.
Julian S. Sachs, Milwaukee County, transferred to Florida.
Hertha Tarrasch, Rock County.

DEATHS

George W. Leitch, Milwaukee County, August 21, 1963.
William H. Bayer, Lincoln County, August 23, 1963.
Claus T. Droege, Douglas County, September 3, 1963.
George R. Reay, La Crosse County, September 9, 1963.
Alfred L. Mayfield, Kenosha, September 23, 1963.
Milton M. Spitz, Milwaukee County, October 2, 1963.
George W. Bartels, Rock County, October 21, 1963.
Charlotte B. Slotnik, nonmember, October 29, 1963.
Seth M. B. Smith, Marathon County, October 30, 1963.
Kenneth J. Denys, Brown County, November 2, 1963.

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1964 **Wisconsin**

Feb. 20: UW/SMS "In Depth" Teaching Program on Orthopedics, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Feb. 27–29: University of Wisconsin Postgraduate Course in Newer Concepts and Techniques in Gastrointestinal Disease, Wisconsin Center, Madison.

Feb. 29: Fifth Annual Conference of County Medical Society Officers, State Medical Society headquarters, Madison.

Mar. 19: UW/SMS "In Depth" Teaching Program on Endocrinology, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Mar. 21: Third annual cancer conference for nurses, University of Wisconsin Medical Center's Division of Clinical Oncology and American Cancer Society, Wisconsin Division, Wisconsin Center, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

Apr. 16–17: Institute for Hospital Administrators, Trustees, and Chiefs of Staff, Milwaukee.

Apr. 17–18: Health Fads & Fallacies Conference, State Medical Society of Wisconsin, Port Edwards.

Apr. 27–29: Annual session, Wisconsin State Dental Society, Milwaukee.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

1964 **Out-of-State**

Feb. 2–8: Workshop in Teratology, University of Florida, Gainesville.

Feb. 7–8: Congress of the Professions, Lansing, Mich.

Feb. 17–19: Canadian-American Medical and Dental Ski Association meeting, Harbor Highlands, Harbor Springs, Mich. Sec-Treas: T. J. Trapasso, M.D., 816 Ashmun St., Sault Ste. Marie, Mich.

Feb. 18–20: Course in Obstetric Problems in Private Practice, Medical College of Georgia, Augusta.

Feb. 29–Mar. 5: International Academy of Proctology Sixteenth Annual Teaching Seminar, Deauville Hotel, Miami Beach, Fla.

Mar. 1–6: American College of Allergists Graduate Instructional Course, Twentieth Annual Congress, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Mar. 2–5: New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Mar. 9–13: Postgraduate Course No. 13, The Physiologic Basis of Electrocardiography, American College of Physicians, University of Utah College of Medicine, Salt Lake City.

Mar. 16–18, 23–25: Clinical Reviews, Mayo Clinic and Mayo Foundation, Theater, Mayo Civic Auditorium, Rochester, Minn.

Mar. 16–19: American College of Surgeons, New Orleans, La.

Mar. 16–21: Fifth postgraduate course in Medical Technology, University of Colorado School of Medicine, Denver.

Apr. 13–16: American Industrial Health Conference, Pittsburgh–Hilton Hotel, Pittsburgh, Pa.

May 5–15: Postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," University of Cincinnati College of Medicine and Christ Hospital, Cincinnati.

May 11–14: 35th Annual Scientific Meeting of the Aerospace Medical Association, Americana Hotel, Miami Beach, Fla.

MEDICAL MEETINGS

POSTGRADUATE COURSES

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 1–5: American College of Physicians postgraduate course No. 17, "Recent Advances in Clinical Nutrition," Lemuel Shattuck Hospital, Boston, Mass.

June 8–12: American College of Physicians postgraduate course No. 18, "Recent Progress in Endocrinology," University of Washington School of Medicine, Seattle.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Institute for Cardiopulmonary Diseases

A 9-month tutorial program in Cardiology, September 15, 1964, to June 15, 1965, will be offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif. This will be an intensive program covering the field of cardiovascular diseases and is especially designed for the physician in private practice who wants a year of organized instruction with freedom from direct patient responsibility.

For details, write: E. Grey Dimond, M. D., Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Aerospace Medical Association

The 35th Annual Scientific Meeting of the Aerospace Medical Association will be held May 11–14, 1964, at the Americana Hotel, Miami Beach, Fla. This annual international scientific meeting will bring together more than 2,000 of the world's foremost specialists in aerospace medicine and allied sciences from the United States and many foreign countries, all of whom have an intense interest in improving the safety and health of all persons involved in civil and military aviation and aeronautics.

Further information may be obtained by writing to William J. Kennard, M. D., Executive Vice President, Aerospace Medical Association, Washington National Airport, Washington 1, D. C.

Mayo Clinic Clinical Reviews

The staff of the Mayo Clinic and the faculty of the Mayo Foundation for Medical Education and Research are again presenting Clinical Reviews on March 16, 17, and 18 and March 23, 24, and 25. Because of the large number attending in past years, two identical sessions on successive weeks are being presented. The three-day programs of lectures and discussions will deal with problems of current interest in general medicine and surgery.

The American Academy of General Practice and the College of General Practice of Canada have advised the Committee on Clinical Reviews that Category I credit may be obtained by members of the American Academy of General Practice or the College of General Practice of Canada attending.

The registration fee for the programs is $10.00. Those wishing to attend should communicate with M. G. Brataas, Mayo Clinic, Rochester, Minn., indicating which session they would prefer to attend.

UW/SMS "In Depth" Teaching Program

The fourth "in-depth" teaching program sponsored by the University of Wisconsin Medical School and the State Medical Society will be held Thursday, February 20. The program on orthopedics is entitled "The Aching Back."

The frequency with which afflictions of the low back are encountered suggests that major attention will be restricted to this area. It is the purpose of the course to provide the family physician with information on the fundamental mechanics of the back, and to provide him with practical information which he can apply to diagnosis and management of this common problem.

The first part of the day, the clinic to be held at Wisconsin General Hospital, will feature "Functional Anatomy and Mechanics of the Lumbosacral Area," by Dr. Jack Heiden, Instructor of Orthopedic Surgery; "Orthopedic Aspects and Examination of the

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Low Back: Case Presentations," by Dr. Herman Wirka, Professor of Orthopedic Surgery; and "X-Ray Evaluation and Differential Diagnosis," by Dr. Henry Okagaki, Assistant Professor of Orthopedic Surgery, University of Wisconsin Medical School.

The afternoon program, to be held at the State Medical Society building, 330 East Lakeside, Madison, will present the following: "Treatment of Low Back Pain: Conservative Management," by Dr. Peter Golden, Assistant Clinical Professor of Orthopedic Surgery; "Physical Medicine: The Family Physician and the Aching Back," by Dr. Harry Bouman, Professor of Physical Medicine, University of Wisconsin Medical School; and "The Intervertebral Disc: Its Role in Low Backache," by Dr. James Stack, Professor of Orthopedic Surgery, Northwestern University School of Medicine, Chicago.

University of Colorado Postgraduate Course

The University of Colorado School of Medicine announces the Fifth Postgraduate Course in Medical Technology, Mar. 16 to 21, 1964, at Denver, Colo. This general course will cover the major phases of

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Mid-Western

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Berlin, Wisconsin

MEDICAL MEETINGS *continued*

medical technology. It is designed primarily for the medical technologist and emphasis will be placed upon the practical aspects of laboratory work. Also, new developments will be discussed. Outstanding guest speakers will be featured along with formal lectures, discussion workshops, panels, demonstrations, exhibits, hospital tours, mountain tours and a banquet and entertainment.

It is co-sponsored by the Colorado State Society of Medical Technologists and the University of Colorado School of Medicine. For a detailed program and further information write to: The Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Changes in ACOP Postgraduate Courses

The American College of Physicians has announced changes in arrangements affecting two of its 1963–1964 Postgraduate Courses.

Two courses have been redesignated in number (due to a change in dates for one course). "Recent Advances in Clinical Nutrition," which will be held at Lemuel Shattuck Hospital, Boston, Mass., June 1–5, 1964, is now Course No. 17. "Recent Progress in Endocrinology" is now Course No. 18.

Announcing THE TWENTY-SEVENTH ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 2, 3, 4, 5, 1964

GUEST SPEAKERS

Nicholas M. Greene, M. D., New Haven, Conn.
ANESTHESIOLOGY

Adolph Rostenberg, Jr., M. D., Chicago, Ill.
DERMATOLOGY

Arthur P. Klotz, M. D., Kansas City, Kans.
GASTROENTEROLOGY

J. Roswell Gallagher, M. D., Boston, Mass.
GENERAL PRACTICE

Roger B Scott, M. D., Cleveland, Ohio
GYNECOLOGY

George R. Herrmann, M. D., Galveston, Tex.
INTERNAL MEDICINE

William C. Thomas, Jr., M. D, Gainesville, Fla.
INTERNAL MEDICINE

John B. Reckless, M. D., Durham, N. C.
NEUROPSYCHIATRY

Robert A. Cosgrove, M. D., Jersey City, N. J.
OBSTETRICS

Roy O. Scholz, M. D., Baltimore, Md.
OPHTHALMOLOGY

Otto E Aufranc, M. D., Boston, Mass.
ORTHOPEDIC SURGERY

Paul H. Holinger, M D., Chicago. Ill.
OTOLARYNGOLOGY

Paul K. Lund, M. D., Seattle, Wash.
PATHOLOGY

Margaret Lyman, M. D., New York, N. Y.
PEDIATRICS

David S. Carroll, M. D., Memphis, Tenn.
RADIOLOGY

C. Barber Mueller, M. D., Syracuse, N. Y.
SURGERY

Lloyd M. Nyhus, M. D., Seattle, Wash.
SURGERY

John K. Lattimer, M. D., New York, N. Y.
UROLOGY

The Lawson Memorial Lecture
Isidor S. Ravdin, M. D., Philadelphia, Pennsylvania

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, technical exhibits and entertainment for visiting wives.

(All-inclusive registration fee—$20.00)

THE CLINICAL TOUR TO EUROPE VISITING LISBON, MADRID, ROME, VIENNA, BERLIN, AND PARIS
Leaving March 7 via air and returning March 28, 1964

For information concerning the Assembly meeting and tour write Secretary, N. O. Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, La. 70112

Dates for "Recent Progress in Enodcrinology" have been changed from May 25–29, 1964, to June 8–12, 1964. The newly designated Course No. 18 will be held at the same location—University of Washington School of Medicine, Seattle, Wash.

The 1963–1964 Postgraduate Courses are part of the continuing postgraduate educational activities of the American College of Physicians, which represents more than 11,600 internists and specialists in related fields.

American College of Surgeons

Surgeons and graduate nurses are invited to the tenth annual joint meeting of the American College of Surgeons in New Orleans, March 16–19, 1964. The headquarters hotel for doctors will be the Roosevelt, and for nurses the Jung.

This is the College's only four-day meeting for 1964 and the only meeting with a program for nurses. This joint meeting pioneered in Cleveland in 1955 and has been a success ever since.

The scope of the meeting approaches that of the annual Clinical Congress. Doctors' sessions will be held in general surgery and in gynecology and obstetrics, ophthalmic surgery, otolaryngology, urology, proctology, neurologic, orthopedic, plastic, and thoracic surgery. There will be daily "How I Do It" nonoperative clinics—educational demonstrations by surgeons noted for specific techniques, scientific papers, panel discussions, selected films, and industrial exhibits of interest.

Panel discussions will be held with doctors and nurses sharing the rostrum in discussions of mutual problems. Special films will also be shown. The nurses will be guests of the College, and pay no registration fee.

Advance housing registration forms, giving hotel rates and registration hours, may be obtained by writing to the College headquarters: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago 11, Illinois.

SMS ANNUAL MEETING • MAY 11-12-13, 1964

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Adam Fueredi, M. D.
L. O. Mastalir, M. D.

Wisconsin Psychiatric Association

The Sixth Annual Meeting of the Wisconsin Psychiatric Association will be held January 31 to February 1 at the State Medical Society Building, 330 East Lakeside, Madison.

Registration will be held at 10:00 a.m. on Friday, January 31. The Welcome, at 11:00, will be given by Dr. William J. Egan, Milwaukee, President of the State Medical Society. Dr. Keith Keane, Appleton, President of the Wisconsin Psychiatric Association, will preside over this session which will feature "Community Planning for Emotionally Disturbed Children and Their Families," by Dr. Cotter Hirschberg, Topeka, Kan., with Dr. Robert E. O'Connor, Madison, serving as discussant.

The 1:30 to 4:30 p.m. session, presided over by Dr. Edward Burns, Madison, President of the Southern Chapter, will have "Social Aspects of Mental Illness," by Martin Loeb, Ph.D. The panel discussants are Dr. Charles Landis, Milwaukee, moderator; Dr. Raymond Headlee, Milwaukee; Dr. Charles Wunsch, Green Bay; Dr. Milton Miller, Madison; and David Mechanic, Ph.D.

Dr. B. Cullen Burris, President of the Milwaukee Chapter, will preside over the 9:00 to 12:00 a.m. session on Saturday, February 1. "The Developmental Phases of the Psychiatrist," will be discussed by Dr. Joseph Kepecs, Chicago, Ill. The discussion group leaders and their recorders, respectively, are: Dr. Josef Kindwall, Milwaukee, Dr. Henry Everett, Madison; Dr. William Lewis, Madison, Dr. Edward Houfek, Sheboygan; Dr. George Martin, Milwaukee, Dr. Albert Fisher, La Crosse; Dr. Albert Lorenz, Eau Claire, Dr. William Lorton, Wauwatosa; and Dr. Ervin Teplin, Milwaukee, Dr. Jack Edson, Waukesha.

Doctor Lorenz, President of the Northern Chapter, will preside over the 1:30 to 4:00 p.m. session which will include reports of discussion groups, with Doctor Kepecs as moderator. Dr. H. Kent Tenney, Madison, will present "A Pediatrician's View of Preventive Psychiatry," with Dr. Ronald Kyllonen, Madison, as discussant.

The annual business meeting will be held at 4:00 p.m., followed by the banquet, at 7:00 p.m., to be held at the Park Motor Inn, 22 South Carroll, Madison. James Crow, Ph.D., acting dean of the University of Wisconsin Medical School, the featured banquet speaker, will present a talk on "Social Implications of New Genetic Knowledge."

SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1964–June 30, 1964

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION
MADISON, WISCONSIN 53703

Location	*Date*
Manitowoc	February 19 and 20
Ashland	February 27 and 28
Racine	March 4 and 5
Marinette	March 11
Kenosha	March 18 and 19
Superior	April 2
Eau Claire	April 8 and 9
Wausau	April 14
Chippewa Falls	April 29 and 30
La Crosse	May 13 and 14
Rhinelander	May 27 and 28
Lancaster	June 3
Darlington	June 4

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison, Wisconsin 53703.

ANNUAL CLINICAL CONFERENCE

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March 2, 3, 4 and 5, 1964

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1964 ANNUAL MEETING

Scientific Program • Preliminary Report

Working closely with the various specialty societies and the Wisconsin Academy of General Practice, the Commission on Scientific Medicine has prepared an outstanding program for the Annual Meeting in Milwaukee, May 11–12–13. To give you an opportunity of planning your attendance, the outline of the Scientific Program is included in the January and February issues of the JOURNAL. The March issue will include full details, and *around the latter part of March a special announcement on the noon scientific luncheons will be sent you.*

PLAN NOW TO ATTEND, AND MARK YOUR CALENDAR FOR THESE DATES

MONDAY, MAY 11

Featuring Obstetrics, Gynecology, and Pediatrics of importance to General Practitioners as well as Specialists in these fields.

MORNING PROGRAMS

1. **OBSTETRICS AND GYNECOLOGY . . . planned by Wisconsin Society of OB and GYN**

   Entire day program will be devoted to general subject of "Pregnancy Wastage." *Sprague H. Gardiner, M.D.* and *Richard W. Stander, M.D.*, both of Indianapolis, Ind., have agreed to participate. Details of program, topics, and additional speakers from Wisconsin will be provided later.

2. **PEDIATRICS . . . planned by Wisconsin Chapter, American Academy of Pediatrics . . . general theme: "Malignancy in Children"**

   A. LEUKEMIA IN RELATION TO GENETICS: *Wayne H. Borges, M.D.*, Chicago. Discussant: *Samuel McCreadie, M.D.*, Milwaukee

   B. CASE PRESENTATIONS ON "MALIGNANCY IN CHILDREN" provided by Departments of Pediatrics at Marquette University School of Medicine and Children's Hospital, Milwaukee. Panelists: *Wayne H. Borges, M.D.*, Chicago; *Samuel McCreadie, M.D.*, Milwaukee; *Anthony V. Pisciotta, M.D.*, Milwaukee

NOON LUNCHEONS

1. **University of Wisconsin Alumni**
2. **Marquette University Alumni**
3. **Roundtables:**

   A. THE IRONIC RETICULOCYTE: *Wayne H. Borges, M.D.*, Chicago

   B. SURGICAL EMERGENCIES IN THE NEWBORN: *Thomas Boles, M.D.*, Columbus, O.

   C. THE OBSTETRICIAN AND PREMATURITY: *Sprague H. Gardiner, M.D.*, Indianapolis, Ind.

   D. ANTENATAL PREDICTION OF ERYTHROBLASTOSIS FETALIS: *Richard W. Stander, M.D.*, Indianapolis, Ind.

AFTERNOON PROGRAMS

1. **Obstetrics and Gynecology . . . continuation of morning program**
2. **Pediatrics . . . continuation of morning program**

   A. ABDOMINAL MASSES IN INFANT AND CHILDREN: *Thomas Boles, M.D.*, Columbus, O. Discussant: *John R. Pellett, M.D.*, Madison

   B. PANEL AND CASE PRESENTATIONS . . . cases provided by University of Wisconsin Medical School, Madison. Panelists: *John R. Pellett, M.D.*, Madison; *Donald Babbitt, M.D.*, Milwaukee; *Thomas Boles, M.D.*, Columbus, O.; *Samuel McCreadie, M.D.*, Milwaukee

EVENING PROGRAM

New Research at the University of Wisconsin and Marquette University . . . presented by the Wisconsin Society of Internal Medicine, in cooperation with the two medical schools

TUESDAY, MAY 12

Featuring Medical Genetics and its application to clinical medicine . . . plus a very practicable application of antidepressant drugs in Psychiatry.

MORNING PROGRAMS

1. **MEDICAL GENETICS: A CLINICAL FIELD . . . planned by Wisconsin Society of Internal Medicine and Wisconsin Society of Pathologists**

   A. TITLE PENDING: *James Crow, Ph.D.*, Madison

   B. DNA METABOLISM AND ITS INFLUENCE ON PROTEIN SYNTHESIS: *Charles Heidelberger, Ph.D.*, Madison

   C. MECHANICS OF CHROMOSOME ANALYSIS: *Stanley Inhorn, M.D.*, Madison

   D. PANEL (TITLE PENDING): Moderator, *David Yi-Yung Hsia, M.D.*, Chicago. Participants: *James Crow, Ph.D.*, *Charles Heidelberger, Ph.D.*, and *Stanley Inhorn, M.D.*, Madison

NOON LUNCHEONS

1. **Roundtables:**

   A. JAUNDICE IN THE NEWBORN INFANT: *David Yi-Yung Hsia, M.D.*, Chicago. Official luncheon of Wisconsin Society of Pathologists, but open to all MDs.

   B. TITLE PENDING: *Arno Motulsky, M.D.*, Seattle, Wash. Official luncheon of Wisconsin Society of Internal Medicine but open to all MDs.

C. MAINTENANCE THERAPY WITH PSYCHOTROPIC DRUGS: *Burtrum C. Schiele, M.D.*, Minneapolis, Minn. Official luncheon of Wisconsin Psychiatric Association, but open to all MDs.
D. RECENT ADVANCES IN THERAPY: *Ovid Meyer, M.D.*, Madison
E. RESUME OF CONTROVERSIAL ASPECTS OF BREAST SURGERY: *Robert Hickey, M.D.*, Madison

2. CES Foundation Annual Meeting of Trustees and Directors

AFTERNOON PROGRAMS

1. MEDICAL GENETICS: A CLINICAL FIELD . . . continuation of morning program
   A. INBORN ERRORS IN METABOLISM: *David Yi-Yung Hsia, M.D.*, Chicago. William Beaumont Memorial Lecture sponsored by the CES Foundation
   B. CLINICAL APPLICATIONS OF MEDICAL Genetics: *Arno Motulsky, M.D.*, Seattle, Wash.
   C. PANEL (TITLE PENDING): Moderator: Pending. Participants: *David Yi-Yung Hsia, M.D.*, others pending
2. PSYCHIATRY . . . planned by Wisconsin Psychiatric Association
   A. CURRENT PERSPECTIVES ON ANTIDEPRESSANT DRUGS: *Burtrum Schiele, M.D.*, Minneapolis, Minn. Rogers Memorial Lecture of the Rogers Memorial Hospital, Oconomowoc. Discussant: *William Heywood, M.D.*, Marshfield
   B. PANEL ON "OFFICE AND HOSPITAL USE OF TRANQUILIZING DRUGS: Moderator, *Milton Miller, M.D.*, Madison. Participants: *Earl J. Jochimsen, M.D.*, Sheboygan; *William L. Lorton, M.D.*, Wauwatosa; *Gilbert Tybring, M.D.*, Madison; and *Robert Urbanek, M.D.*, Beaver Dam

WEDNESDAY, MAY 13

Featuring Dermatology, Orthopedic Surgery, Anesthesiology, Radiology, Ophthalmology and Otolaryngology, and Surgery.

1. SPECIAL PROGRAM ON OCCUPATIONAL DERMATOSIS . . . planned by Wisconsin Dermatological Society

   Entire program will consist of cases (with some patients presented) to discuss various facets of the problem of occupational dermatology. Guest discussant: *Donald Birmingham, M.D.*, Cincinnati, O.

   Each case will be discussed separately by:
   - A physician: The matter of diagnosis and treatment
   - A lawyer: Legal aspects of the case
   - A safety engineer
   - An insurance man
2. SPECIAL PROGRAM ON FRACTURES OF THE KNEE AND ANKLE JOINTS . . . provided by Wisconsin Society of Orthopedic Surgeons
   A. FRACTURES ABOUT THE KNEE JOINT: *Harry Hall, M.D.*, Minneapolis, Minn.
   B. PANEL: TREATMENT OF FRACTURES ABOUT THE ANKLE JOINT: Moderator: *Paul Collopy, M.D.*, Milwaukee. Participants: *Harry Hall, M.D.*, Minneapolis, Minn.; *Herman Wirka, M.D.*, Madison, and *Chester Satler, M.D.*, Kenosha

NOON LUNCHEONS

1. Anesthesia
   A. THE DEVELOPMENT OF ATELECTASIS DURING ANESTHESIA: *Douglas Eastwood, M.D.*, Charlottesville, Va.
   B. CLINICAL HYPOTENSION WITH HALOTHANE: *Evan Frederickson, M.D.*, Kansas City
2. Dermatology
   USE AND MISUSE OF THE PATCH TEST IN THE DIAGNOSIS OF OCCUPATIONAL SKIN DISEASE: *Donald Birmingham, M.D.*, Cincinnati, O.
3. Radiology
   RADIOLOGIC ASPECTS OF ACUTE GASTROINTESTINAL HEMORRHAGE: *Buell C. Buchtel, M.D.*, New Orleans, La.
4. Orthopedic
   THE FLEXION AND EXTENSION INJURIES TO THE NECK FOLLOWING A REAR-END AUTO COLLISION: *Harry E. Hall, M.D.*, Minneapolis
5. Pharmacology
   NEW CONCEPTS IN THE DRUG THERAPY OF ANGINA PECTORIS: *Harold Hardman, M.D., Ph.D.*, Milwaukee
6. Genetics
   A PUBLIC HEALTH PROBLEM: *James Crow, Ph.D.*, Madison. Official luncheon of Public Health Physicians, but open to all MDs.
7. Nonscientific
   PAST PRESIDENT'S LUNCHEON

AFTERNOON PROGRAMS

1. ANESTHESIOLOGY . . . planned by Wisconsin Society of Anesthesiologists
   A. SOME ASPECTS OF NITROUS OXIDE PHARMACOLOGY AND TOXICITY AFFECTING CLINICAL USE: *D. W. Eastwood, M.D.*, Charlottesville, Va.
   B. NOTES ON THE PRODUCTION OF ANALGESIA WITH NITROUS OXIDE: *Evan Frederickson, M.D.*, Kansas City, Kan.
2. OPTHALMOLOGY AND OTOLARYNGOLOGY . . . planned by the State Medical Society Scientific Section on O & O
   A. LUNCHEON
   B. BUSINESS MEETING
   C. CHOICE OF TREATMENT IN DISLOCATION OF THE LENS: *Paul A. Chandler, M.D.*, Boston, Mass. Sponsored by Milwaukee Oto-Ophthalmic Society
   D. MIDFACIAL INJURIES: *Jerome A. Hilger, M.D.*, St. Paul, Minn. Sponsored by Wisconsin Otolaryngologic Society
3. RADIOLOGY . . . planned by Wisconsin Radiological Society
   A. RADIOLOGIC EVALUATION OF HYPERTENSION OF RENAL ORIGIN: *Buell C. Buchtel, M.D.*, New Orleans, La.
   B. TITLE PENDING: Speaker pending
   C. THE ROLE OF RADIOTHERAPY IN THE TREATMENT OF CANCER: *Isadore Lampe, M.D.*, Ann Arbor, Mich.
4. SURGERY . . . planned by Wisconsin Surgical Society

   Guest lecturer: *Robert Tidrick, M.D.*, Iowa City, Ia.

   Balance of program will be presented by members of the Wisconsin Surgical Society, details of which will be announced later.

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Jack Teasley, and Dr. and Mrs. Milton Gutglass, Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 11–13, 1964

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his **wife.**

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs. Jack Teasley, Milwaukee, on or before April 1, 1964. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 11, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Wednesday, May 13.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Jack Teasley, 7421 North Crossway Road, Milwaukee, Wis. 53217, BEFORE APRIL 1, 1964.

I plan to submit the following entry or entries for the 1964 MEDICAL ART SALON at the Milwaukee Auditorium, May 11–13.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

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State Medical Society members, through the action of the local County Advisory Committees, determine what fee level is "customary, usual and reasonable."

WHAT IS A COUNTY ADVISORY COMMITTEE?

A County Advisory Committee is appointed by the president of the county medical society and meets periodically to review claims (less than one percent of total claim volume) referred to the committee by the WPS claims department.

> The Committee reviews the facts in each case and if it concludes that the fee is proper it will advise WPS that the charges are within the intent of the "no fee schedule" principle as it applies in that medical community.

This procedure places the responsibility and the authority for determining fees where it belongs . . . with the local physician.

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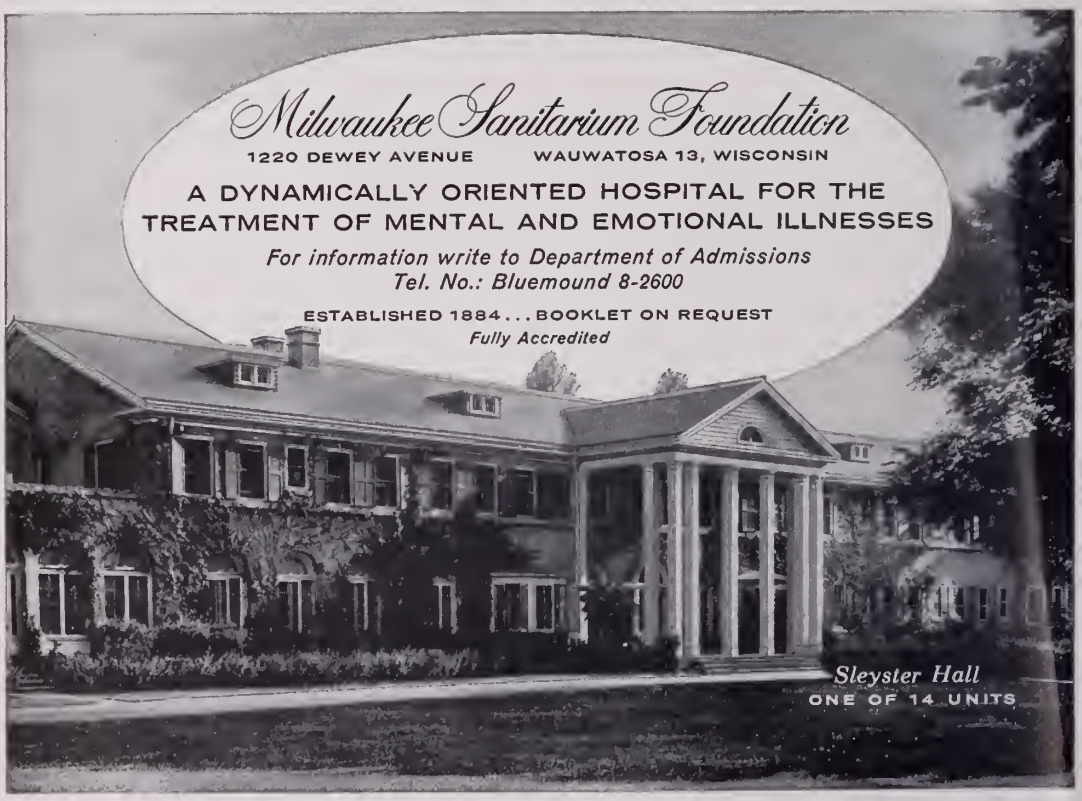

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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Journal
Established 1903
Annual Subscription-------$6.00
Single Copy---------- 1.00
Previous Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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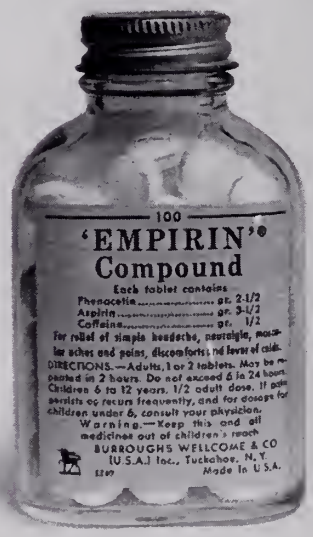

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LETTERS

"STRONG ALLY" APPRECIATED

To DNG:

Your editorial, "Strong Ally," appearing in the November issue of the *Wisconsin Medical Journal* is truly appreciated. I am confident the entire membership of the Wisconsin State Medical Assistants Society joins me in thanking you for your kind remarks. This recognition and evaluation of our organization serves to strengthen our purposes for continued efforts in improving our services to the medical profession and the people of Wisconsin.

MRS. ALEEN PIEPENBURG
Public Relations Chairman
Wisconsin State Medical Assistants Society

LABELING OF PRESCRIPTIONS

To WMJ:

The following comments form the basis for suggesting a specific change in the labeling of prescriptions supplied to patients: The medication should be identified on the label. This suggestion derives from the conviction that physicians should treat each patient as a peer. One requisite of this type of patient–physician relationship would be an obligation on the part of the physician to inform the patient something about the nature of his illness. One is struck by the number of people who are of the impression that physicians do not tell them the truth. The custom of writing a prescription in Latin has waned to the vanishing point, and the time has passed when a physician's prescription should be a secret communication to the pharmacist. For the majority of prescriptions written today, the pharmacist does no compounding, but rather dispenses prefabricated medications. A prescription which does not identify the drug by name is incomplete and potentially dangerous.

The use of potent drugs in therapy has increased markedly in the past two decades and will continue. Current medical reports indicate that serious and even fatal drug reactions are not rare. Signs and symptoms may not be considered as due to a drug reaction unless the physician knows which drugs the patient is taking. Labels which identify the drug in a prescription would surely save money, time, and even a few lives because then any physician seeing the patient can ask what medications are being taken or he can ask to see the prescription bottle. It is quicker, more economical, and more accurate to read the label on a bottle than to telephone another physician for this information. The pathologic physiology of disease is so dynamic that modifications resulting from drugs may confuse the diagnostic and therapeutic horizon if the physician is unaware of the use of these drugs.

Due to the great amount of travel in our society, patients will be seen by new physicians unexpectedly in new places. In addition, in larger cities, the custom of going to obstetricians, otolaryngologists, dermatologists, psychiatrists and other specialists independently will mean that the family physician or these consultants may see drug effects due to medications they themselves have not prescribed. Surely it must be common for dermatologists to see people with a skin rash due to medications prescribed by another physician. Medical consultation is ubiquitous in our society, and in the hospital in which the writer practices all patients are referred by other physicians. When a new patient tells me that he has been taking a little white pill prescribed by Doctor X, and a large pink pill capsule prescribed by Doctor Y, the patient's estimate of me as a physician sinks perceptibly when I fail to identify either of these medications from his story, or from their appearance. How convenient it would be if the prescription were labeled, "Digitoxin, 0.2 mg.", or "Dicoumarol, 25 mg.". This knowledge would immediately allow the doctor presently seeing the patient to pursue the history of the illness in a pertinent manner, and one might have a ready explanation for the concomitant complaint of nausea. Patients with anemia are common. The easiest way to exclude pernicious anemia as the cause of anemia today is to learn that the patient has received, by injection, generous quantities of vitamin B_{12} for the past several months. The identification of multi-vitamin capsules is also of importance, because it has been shown that some patients with pernicious anemia may develop neurological disease before the anemia becomes apparent if they are receiving folic acid by mouth. Suicidal attempts through barbiturate ingestion can be more effectively handled if the medicine can be identified by reading the label, rather than by chemical analysis or presumption. The administration of vitamin K to patients receiving Dicoumarol may be life-saving in certain instances. The use of nalorphine to counteract overdosage from morphine is potentially life-saving.

For patients who know they are sensitive to certain drugs it is doubly important that any prescriptions be labeled as to the drug content, because the physician's history may not have elicited this drug

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing.

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sensitivity. The patient may have forgotten about it for the moment, but will surely be reminded when he sees the name of the known offender on the prescription bottle.

Undesirable drug reactions are common and should be of interest to all medical people. The Food and Drug Administration is currently attempting a moderately broad pilot study of the incidence of undesirable drug reactions. I suggest that the accuracy of any information about drug reactions would be enhanced by labeling all prescription bottles.

The medical profession should give consideration to the requirement that all prescription labels indicate the generic or trade-name of the drug, and the quantity per unit, unless the doctor has written to the contrary on the original prescription.

ROBERT F. SCHILLING, M.D.
University Hospitals
Madison, Wisconsin

MEDICAL JOURNALISM AWARDS

The American Medical Association has announced a $5,000 medical journalism awards program "to recognize journalism that contributes to a better public understanding of medicine and health in the United States."

Awards of $1,000 each will be presented for outstanding reporting on health and medicine in five categories—newspapers, magazines, radio, television, and in newspaper editorial writing, said F. J. L. Blasingame, M.D., executive vice-president of the AMA.

The awards are intended for recognition of outstanding reporting of the scientific and clinical aspects of medicine, Dr. Blasingame said. Awards will be presented for the first time in 1965, based on work published or broadcast during the calendar year of 1964.

Entries will be judged on a basis of accuracy, significance, quality, public interest and impact. Entries will be judged by the 1964 Medical Journalism Awards Committee, which will include outstanding members of the publishing industry, radio and television industry and the medical profession, he said.

Entries may be sent to the 1964 Medical Journalism Awards Committee, American Medical Association, 535 N. Dearborn St., Chicago, Ill. Deadline is Feb. 1, 1965, although entries may be submitted at any time prior to that date.

Newspaper and magazine articles should be submitted in triplicate validating date of publication and showing the material as it was presented to

the public. Entries for radio or television should consist of three copies of the complete script and a 200-word summary of the script, together with film or kinescope of television entries and audio tape or transcription of radio entries. Entrants may make as many entries as they wish.

Each entry should be accompanied by a statement listing title of entry, writer or producer, publication in which the article appeared or station or network over which program was broadcast, date entry was published or broadcast, category for which entry is submitted, name, address and title of person submitting entry. Radio and television films, tapes or kinescopes will be returned if requested.

Categories of competition are:

1. NEWSPAPERS: For a distinguished example of a news or feature story or series in a United States newspaper of general circulation published daily, Sunday or at least once a week.
2. MAGAZINES: For a distinguished example of an article or series in a United States magazine of general circulation published weekly, monthly, quarterly or at other regular intervals.
3. EDITORIAL: For a distinguished example of editorial writing in a United States newspaper of general circulation published daily, Sunday or at least once a week.
4. RADIO: For a distinguished example of reporting on medicine or health on a United States radio station or network.
5. TELEVISION: For a distinguished example of reporting on medicine or health on a United States radio station or network.

The awards will *not* be given for work, however excellent, that involves primarily the relaying of medical knowledge to the medical profession and to allied professions. Members of the medical profession, medical associations and their employees are not eligible to submit entries.

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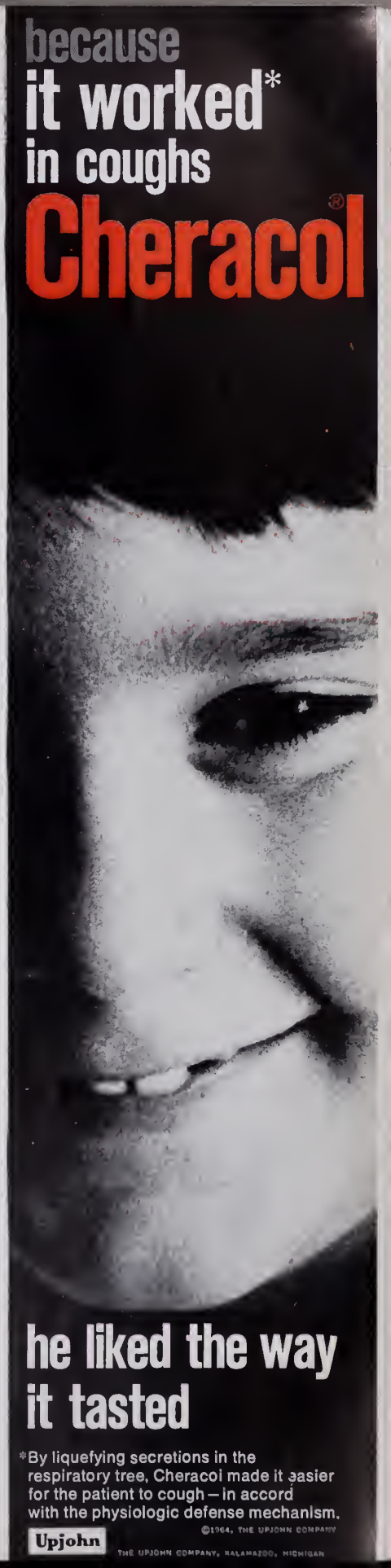

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BARRON–SAWYER–WASHBURN–BURNETT

The Barron–Sawyer–Washburn–Burnett County Medical Society met in Sarona on December 10. The meeting was held at Sarona House. Election of officers for 1964 was held. They are: president, *Dr. Harold Jirsa*, Cumberland; vice-president, *Dr. R. C. Whaley*, Barron; secretary–treasurer, *Dr. John K. Hoyer*, Rice Lake; delegate, *Dr. C. J. Strang*, Barron; alternate, *Dr. Robert Anderson*, Cumberland; and censor (term expires in 1966), *Dr. Noland Eidsmoe*, Rice Lake. New members are: *Dr. M. E. Gillespie*, Rice Lake; *Dr. Peter Lameka*, Rice Lake; and *Dr. John F. Stageman*, Grantsburg.

BROWN

The Brown County Medical Society met in the Northland Hotel, Green Bay, on November 14. Fifty doctors attended.

Dr. R. J. Samp, assistant professor of surgery, Division of Clinical Oncology, University of Wisconsin Medical School, Madison, addressed the Society on "Cancer Therapy." A business meeting followed.

Mr. C. H. Crownhart and Mr. Robert Murphy of the State Medical Society, Madison, spoke relative to the many public health bills (about 50) currently before the Legislature. They warned against continuous efforts being made by pressure groups, such as faith healers, chiropractors, physical therapists, clinical psychologists, and podiatrists to call themselves "doctors" and be independent. The great drive by the optometrists (Bill 134, A.) is an example. Doctors were urged to communicate with the following members of the Senate Judiciary Committee regarding this bill: Senators A. J. Busby, Milwaukee; E. D. Morton, Kenosha; E. C. Keppler, Sheboygan; J. M. Potter, Port Edwards; L. S. McParland, Cudahy; and D. A. Donnelly, Eau Claire. All may be contacted by writing the Legislative Post Office, State Capitol, Madison.

Dr. J. F. Mokrohisky, Green Bay, gave a thorough analysis of the proposed new fee schedule for Brown County Medical Society to be based on the California Medical Association Relative Value Studies published in 1960. The Secretary was asked to supply each member of the Society with a copy as soon as possible.

Dr. Lyle H. Edelblute, Green Bay, asked that the donation of $600.00 for the year 1963 to the three Green Bay hospital libraries be granted. The motion was granted. Doctor Edelblute also briefly discussed the interim meeting of the House of Delegates of October 18–19 held in Madison.

Dr. A. J. McCarey, Green Bay, addressed the Society and analyzed the extensive and valuable work done by the Charitable, Educational and Scientific Foundation of the State Medical Society. The Society voted to donate $500.00 for the year 1963.

Physicians whose names appear in italic are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS

DANE

The Dane County Medical Society met December 10 at the State Medical Society Building, Madison. After the call to order by *Dr. Palmer Kundert*, Madison, president of the Society, *Dr. H. M. Suckle*, Madison, discussed the results of the fall session of the House of Delegates.

"Gram-Negative Bacteremia and Theoretical Aspects of Its Treatment" was presented by *Dr. B. A. Waisbren*, associate professor of medicine, Marquette University School of Medicine.

New members of the Society include *Dr. Dennis R. Howard* who was born in Chicago, Ill., and graduated from the University of Wisconsin Medical School in 1962. Doctor Howard served his internship at Madison General Hospital and is currently in general practice in Madison. *Dr. John R. Sadd* was born in Evergreen Park, Ill., and received his medical education at the University of Rochester, graduating in 1959. He served his internship at University Hospitals, Madison, and is currently a resident in surgery at University Hospitals. *Dr. Elvira C. Seno*, was born at Slades Corners and graduated from the University of Wisconsin Medical School in 1943. She served her internship at St. Joseph's Hospital, Marshfield. She completed her M. S. degree in bacteriology at the University of Wisconsin also. Doctor Seno is employed at Mendota State Hospital, Madison.

Dr. David E. Goodnough, was born at Watertown, N. Y. He received his medical degree from the University of Wisconsin Medical School in 1959. He served his internship at Orange County General Hospital at Orange, Calif. Doctor Goodnough is currently an anesthesiology resident at University Hospitals. *Dr. William J. McAweeney*, was born at Boston, Mass., and graduated from the George Washington University School of Medicine in 1959. He served his internship at St. Vincent Hospital in Worchester, Mass., and completed his residency in internal medicine at St. Vincent Hospital and Lemuel Shattuck Hospital, Boston. Doctor McAweeney is in private practice in Madison.

Dr. William E. Prickman, was born at Rochester. Minn., and received his medical education at the University of Minnesota Medical School. He received his medical degree in 1959 and served his internship at St. Mary's Hospital in Duluth, Minn. Doctor Prickman completed his residency in ophthalmology at the Mayo Clinic and is now in private practice in Madison.

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*Donnelly, J.: A.M.A. Arch. Environmental Health 6:697, June, 1963

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Dr. Louis F. Warrick, Jr., is a native of Madison. He received his medical education from George Washington University where he graduated in 1957. He served his internship at Emergency Hospital in Washington, D.C., and completed his residency in internal medicine at Washington Hospital Center. Doctor Warrick is now in private practice in Madison.

The regular January meeting, held at the State Medical Society Building, featured Dr. Alan F. Guttmacher of New York City, chairman of the Medical Advisory Board of the Planned Parenthood Federation of America. He spoke to the group on "The Social and Medical Dilemma of Excessive Population Growth."

KENOSHA

The Kenosha County Medical Society met December 5 at the Elks Club, Kenosha, it was reported by *Dr. Gene Armstrong*, Kenosha, secretary.

LA CROSSE

The La Crosse County Medical Society met in La Crosse on December 16 at the Fireside Restaurant. The speaker was Mr. Perry Anderson who spoke on "Disability Decision." Sixty-seven were present. New officers elected were *Dr. Mark O'Meara*, La Crosse, as vice-president of the Society, and *Dr. David Morris*, West Salem, as delegate. A new member of the Society, a transfer from Middlesex South District Medical Society, is *Dr. John E. Reinert*, La Crosse.

Milwaukee Journal Photo

The new president of the Medical Society of Milwaukee County is Dr. Robert S. Haukahl, (right) Milwaukee. Shown with him at the Society's annual meeting in December at the Wisconsin Club, Milwaukee, are Dr. Robert F. Purtell (left), Milwaukee, president-elect; and Dr. Robert A. Frisch, Milwaukee, past-president.

OZAUKEE

The Ozaukee County Medical Society met in Mequon in November, and election of officers was held, it was reported by the secretary, *Dr. Philip W. Wallestad*, Port Washington. *Dr. Kenneth F. Pelant*, Grafton, was elected president, *Dr. George Savage*, Port Washington, vice-president and *Dr. Allen Misch*, Cedarburg, was elected secretary. A new member of the Society is *Dr. Howard Albright*, Thiensville. The next meeting was held January 23 at the Grafton Hotel, Grafton.

PIERCE–ST. CROIX

The Pierce–St. Croix County Medical Society met at the Sports Club in Hudson on January 21, it was reported by *Dr. P. H. Gutzler*, River Falls, secretary of the Society.

RACINE

The 1964 officers of the Racine County Medical Society are: president, *Dr. Frank J. Scheible*, Racine; president-elect, *Dr. Richard J. Mayer*, Racine; secretary, *Dr. Leslie E. Jones*, Racine; and treasurer, *Dr. Elizabeth Steffen*, Racine; *Dr. Warren H. Williamson*, Racine, is the past president. Additional elected members of the executive committee are *Dr. Robert S. Wright*, Racine, and *Dr. B. V. Winter*, Union Grove. The delegates are *Dr. V. J. Burch*, Racine, and *Dr. Willaim Henken*, Racine. Alternate

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delegates are *Dr. Richard Minton*, Racine, and *Dr. R. B. Leitschuh*, Racine. Censors include *Dr. Richard J. Fogle*, Racine, 1964; *Dr. Thomas W. Dorman*, Racine, 1965; and *Dr. James C. Cook*, Racine, 1966. The councilor is *Dr. Gordon J. Schulz*, Union Grove.

RICHLAND

The Richland County Medical Society met in Richland Center on January 1 at the Richland Hospital library. Ten were present. *Dr. Alwin Schultz*, University of Wisconsin Medical School, Madison, presented a paper on "Carcinoma of the Female Genital Tract." Future meetings will be held the first Thursday of each month.

SAUK

The Sauk County Medical Society met December 10 at the Ritz, Baraboo. *Dr. Ovid O. Meyer*, Madison, spoke on "Anticoagulant Therapy." The January 14 meeting had *Dr. C. Robert Jackson*, Madison, as speaker. He addressed the group on "Obstetrics and Gynecology Emergencies."

WALWORTH

The Walworth County Medical Society met in Lake Geneva on December 19. *Dr. Robert T. McCarty*, Milwaukee, was the featured speaker. Election of officers was held. They are: *Dr. Henry F. Bischof*, Lake Geneva, president; *Dr. Richard J. Rogers*, Elkhorn, vice president; *Dr. R. S. Galgano*, Delavan, secretary; *Dr. E. D. Sorenson*, Elkhorn, delegate; and Doctor Galgano, alternate.

WOOD

The Wood County Medical Society met in Port Edwards on December 5 at the Paper Inn. *Dr. Donald V. Blink*, Wisconsin Rapids, addressed the Society on "Epidemic Meningitis." At the business session, distribution of Sabin oral polio vaccine type III in the Wood County Sabin Oral Sunday Program was endorsed.

New members include Doctor Blink; *Drs. T. F. Nikolai, J. A. Kunkel, G. E. Porter, A. B. Cameron, R. N. Richards, D. M. Kinkel, W. F. Schorr*, and *F. W. Fletcher*, all of Marshfield.

Election of officers for 1964 was held. They are: president, *Dr. G. H. Handy*, Wisconsin Rapids; vice-president, *Dr. R. J. Rowe*, Marshfield; secretary–treasurer, *Dr. J. W. Rupel*, Marshfield; and censor for a three-year term, *Dr. Norbert Arendt*, Wisconsin Rapids. Delegates are *Dr. E. C. Glenn*, Wisconsin Rapids; and *Dr. Russell F. Lewis*, Marshfield. Alternates are *Dr. W. B. Larkin*, Marshfield; and *Dr. John E. Thompson*, Nekoosa.

SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Dermatological Society

The new officers for 1964 for the Wisconsin Dermatological Society are: president, *Dr. Daniel Hackbarth*, Milwaukee; vice-president, *Dr. Richard Rowe*, Marshfield; and secretary–treasurer, *Dr. Robert B. Pittelkow*, Milwaukee.

Wisconsin Academy of General Practice—Southeastern Chapter

Dr. Morris Siegel, Kenosha, has been elected president of the Southeastern Chapter of the Wisconsin Academy of General Practice. Other officers are: vice-president, *Dr. J. G. Jamieson*, Racine; secretary–treasurer. *Dr. H. L. Schwartz*, Kenosha; and president-elect, *Dr. G. L. Rothenmaier*, Racine. Delegates named were *Drs. R. G. Burnett*, Kenosha; *R. S. Wright* and *R. F. Scheller*, both of Racine. All were elected to a two-year term. The Southeastern Chapter includes Racine, Kenosha, and Walworth counties.

American College of Chest Physicians—Wisconsin Chapter

The American College of Chest Physicians. Wisconsin Chapter, held its fall meeting in November at Stouffers Restaurant, Milwaukee. There was a short business meeting and a scientific program which included: "Hypersensitivity Pulmonary Disease from Exposure to Pigeons," by *Drs. C. Reed* and *Abe Sosman*, Milwaukee; "Determination of Effectiveness of Expectorants by a Method for Measuring Sputum Consistency (Preliminary Study)," by *Drs. Ross Kory* and *S. R. Hirsch*, Milwaukee; and "Selective Cine Angiography in Congenital Heart Disease," by *Drs. John Huston* and *John Amberg*, Milwaukee.

Wisconsin Council of Safety

The 22nd Wisconsin Mid-Winter Safety Conference and Exposition, sponsored by the Wisconsin Council of Safety, was held January 22–24, at the Hotel Schroeder in Milwaukee. Several physicians took part in the various session programs. *Dr. Franklin J. Mellencamp*, Milwaukee, spoke on poisoning with aspirin, and *Dr. George E. Collentine, Jr.*, director of the Burn Center, St. Mary's Hospital, Milwaukee. spoke on emergency care of major and minor burns.

The premier showing of the Wisconsin Council of Safety film, "It Can Happen to You," was held at the noon luncheon on January 23. Through conversations with people in various walks of life, this 28-minute documentary gave the viewer a look at some of Wisconsin's key traffic safety problems. Shortly after the premiere, copies of the film were sent to WCS directors who will arrange for local showings to various organizations within their communities.

The theme for 1964 is Operation "SOK" (Share Our Knowledge), which will consist of monthly mailing of the Council's newsletter which includes suggestions for basic, in-plant safety programs; the National Safety Council's Technical Library Service; training programs through which basic safety ideas will be offered to foremen and supervisors in vocational school courses; seminars dealing with in-plant problems; and a field service to 33 affiliated local safety councils to help them give more service to local employers. All this will be offered on a trial basis for six months to 3,000 nonmember employers with the ultimate goal to eventually establish contact with all 30,000 employers in Wisconsin.

Wisconsin Allergy Society

The Wisconsin Allergy Society held its annual meeting on November 2 in Marshfield as guests of the Marshfield Clinic. The meeting was presided over by acting president *Dr. John Talbot*, Madison. Elections were held and *Dr. John Arkins*, Milwaukee, was chosen president-elect; *Dr. David M. Glassner*, Milwaukee, was chosen secretary–treasurer. Dr. Kenneth Mathews, University of Michigan Medical School, was the guest speaker and discussed "Histamine Release Phenomena." The next meeting of the Wisconsin Allergy Society will be held in conjunction with that of the State Medical Society in May.

Wisconsin Anti-Tuberculosis Association

The annual meeting of the Wisconsin Anti-Tuberculosis Association will be held April 2 and 3, in Milwaukee, at the Coach House. The keynote address will be given by Dr. Katharine R. Boucot, professor of preventive medicine at Woman's Medical College of Pennsylvania.

Other speakers will include Dr. Carroll E. Palmer, director of the research section of the tuberculosis program of the U. S. Public Health Service, and Dr. C. W. L. Jeanes, executive secretary of the Canadian Tuberculosis Association.

Wisconsin Thoracic Society

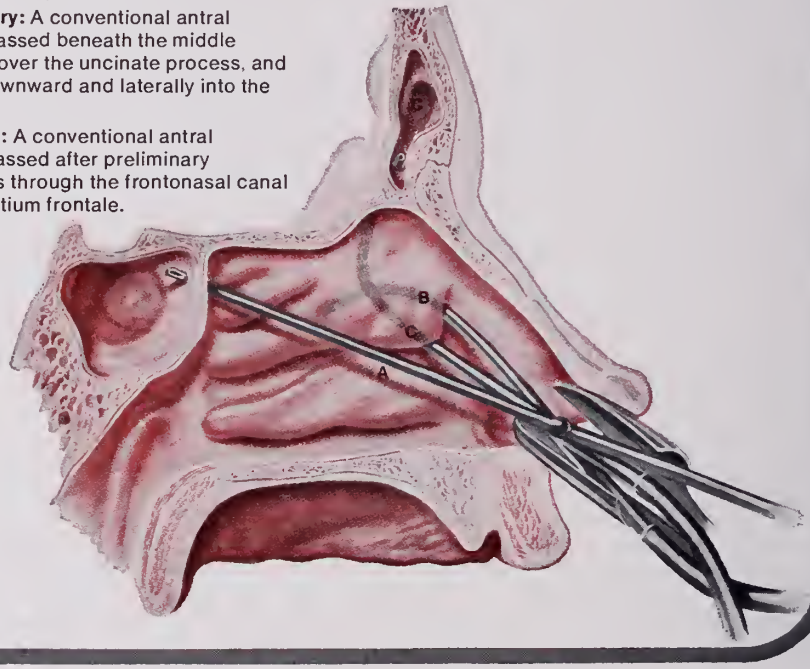
The Wisconsin Thoracic Society will hold its annual meeting on April 4, at the Coach House, Milwaukee, following the Wisconsin Anti-Tuberculosis Association's meeting. The sessions will follow the 1962 and 1963 plan.

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



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can help prevent emergency measures later

Before complications arise in colds and sinusitis, Neo-Synephrine solutions and sprays reduce nasal turgescence on contact — to promote essential aeration and drainage. Turbinates shrink, sinus ostia open and drainage is freed. Relief is instant and the threat of complications is lessened.

In the treatment of sinusitis, the ¼ per cent solution is a preferred vasoconstrictor, "...most closely approximating physiologic composition with the least 'rebound' tendency...."* Gentle Neo-Synephrine is well tolerated by delicate respiratory tissues. Systemic effects are practically nil, post-therapeutic turgescence is minimal and repeated applications do not lessen its effectiveness. Neo-Synephrine has been a standard among vasoconstrictors since 1935.

Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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New York, N. Y.

Winthrop

(1839M)

NEWS OF WISCONSIN PHYSICIANS

Riverside Clinic Adds Dr. Newby

The Riverside Clinic, Menasha, has announced the addition of Dr. Kenneth G. Newby to its staff. Doctor Newby, who is an ophthalmologist, was born in Streator, Ill., and graduated from Valparaiso University, Valparaiso, Ind., in 1953. His medical education was received at the University of Illinois College of Medicine, Chicago, Ill., where he graduated in 1957. Doctor Newby interned at Illinois Central Hospital, Chicago, in 1958. He served his residency in ophthalmology at the University of Minnesota Hospitals from 1960 to 1963. From 1958 through 1960, he served with the Army at a medical installation in the Panama Canal Zone.

Dr. Martins Publishes Paper

Dr. James K. Martins, Eau Claire, recently published an article, "Arthritis and Related Conditions," in the GENERAL PRACTICE magazine, volume 26, number 9, 1963.

Dr. Lustok Heads Mount Sinai

Dr. Mischa J. Lustok, Milwaukee cardiologist, has been appointed chief of the medical staff of Mount Sinai Hospital, Milwaukee, for a two-year term. He succeeds *Dr. David V. Elconin*, Milwaukee. Doctor Lustok is an assistant clinical professor of medicine, Marquette University School of Medicine. He is also president of the Milwaukee Society of Internal Medicine and is a former president of the Wisconsin Medical Alumni Association. He has been chief of the hospital's section of internal medicine and chief of the department of medicine.

Wisconsin Nursing Scholarships

The Wisconsin State Board of Nursing has awarded scholarships totaling $29,925.00 to 22 Wisconsin registered professional nurses for advanced academic preparation, according to information received from Adele G. Stahl, R. N., Secretary, Wisconsin State Board of Nursing.

Dr. Ehrhardt Joins Waupun Clinic

Dr. Alan A. Ehrhardt recently joined the staff of the Waupun Clinic. He is a 1959 graduate of the University of Wisconsin Medical School, Madison. Doctor Ehrhardt spent his internship at Oakland, Calif., prior to two years with the Air Force in the Philippines. He was recently discharged from the service.

Dr. Roessler Leaves UW

Dr. Robert Roessler, Madison, a nationally known psychiatrist, who established the first department of psychiatry at the University of Wisconsin, has resigned from the faculty to accept a post as research professor of psychiatry at the Baylor University College of Medicine, Houston, Tex.

Dr. Lastrilla to Germantown

Dr. Rudolfo S. Lastrilla, a native of the Philippines, has become the new physician for the Germantown area. Doctor Lastrilla was graduated from the University of Santo Tomas College of Medicine, Manila, in 1958, and in 1959 he came to St. Michael's Hospital, Milwaukee, to complete his internship. He finished his general practice residency and is presently the chief surgical resident at St. Michael's.

Mental Health Discussed by Dr. Ganser

Dr. L. J. Ganser, Madison, director of the division of mental hygiene, State Department of Public Welfare, addressed the general meeting of the United Community Council, Green Bay, in November. He discussed "Wisconsins' Action for Mental Health 1963–1965." Doctor Ganser has been with the state division since 1953. He was named superintendent of the Wisconsin Diagnostic Clinic in 1955 and director of the mental hygiene division in 1960. He is a fellow of the American Psychiatric Association.

Dr. Windsor Named to Subcommittee

Dr. Richard B. Windsor, Sheboygan, has accepted an invitation to become a member of the Subcommittee on Medical Care under the President's Committee for Traffic Safety. The announcement was made by Dr. Robert H. Kennedy, field program director of the American College of Surgeons. The medical care aspect of the committee encompasses first-aid care by the layman and many facets of the ambulance problem, scope and mechanism of training ambulance attendants, the speeding ambulance, the economic problems in the community, and the manifest problems in space, equipment, personnel, quality of care in an emergency department. Doctor Windsor is chairman of the State Medical Society's division on safe transportation of the Commission on State Departments.

R. B. Windsor, M.D.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Johnson Attends Air Seminar

Dr. Allen Johnson, Rhinelander, attended an advanced aviation medical seminar in Albuquerque, N. M., recently. The program was sponsored by the Federal Aviation Agency and stressed physiological problems connected with manned space flight and supersonic air transportation.

Dr. Angevine Returns

Dr. D. Murray Angevine, Madison, professor of pathology at the University of Wisconsin Medical School, recently returned from Japan, where he served for one year on the Atomic Bomb Casualty Commission in Hiroshima.

The commission was established in 1947 to study the latent effects of atomic radiation on those who survived exposure to the nuclear blasts exploded over Hiroshima and Nagasaki in August, 1945. The program is significant in that it is the only human experiment of total body irradiation.

The unified program consists of three major studies. The first is the Life Span Study designed to see if the life span of exposed persons is different from those who were not exposed. The second is an Adult Health Study which determines the kind of illnesses experienced by the population. The third is the Pathology Study, which Doctor Angevine directed. It consists of making complete autopsies to discover not only the immediate cause of death, but also the major diseases, whether they were related to death or not.

The work of the commission, which does not include treatment, is sponsored by the American National Academy of Sciences and the Japanese National Institute of Health, with funds from the Atomic Energy Commission.

Dr. Korbitz Joins Monona Grove Clinic

Dr. Robert F. Korbitz, Madison, recently joined the staff of the Monona Grove Clinic in general practice. Doctor Korbitz graduated from the University of Wisconsin Medical School in 1962 and served his internship at St. Luke's Methodist Hospital, Cedar Rapids, Ia. He served as a lieutenant in the Navy from 1952 through 1955.

Dr. Kory Is Guest Lecturer

Dr. Ross C. Kory, Veterans Administration Hospital, Wood, was a guest speaker at the annual meeting of the Western Tuberculosis Association, Portland, Ore., held in September. He spoke on "Evaluation of Function Impairment in Pulmonary Emphysema and Factors Affecting Prognosis." In October, Doctor Kory was a member of the faculty on the postgraduate course on Clinical Cardiopulmonary Physiology of the American College of Chest Physicians in Chicago, Ill., where he discussed "Compartments of Lung Volume and Their Physiologic Significance." He was also a guest speaker in October at the Symposium on Pulmonary Diseases sponsored by the Brooklyn Tuberculosis and Health Association and the State of New York Downstate Medical Center, held in Brooklyn, N. Y., speaking on the topic "The Use of Pulmonary Function Testing in the Diagnosis of Pulmonary Disease."

From November 13 to November 26, Doctor Kory was a visiting lecturer in medicine and physiology at the School of Medicine, Universidad del Valle, Cali, Colombia, South America, as a part of the exchange program sponsored by the Rockefeller Foundation.

Dr. Neeno Aids Easter Seals

Dr. Katsumi Neeno, Janesville, recently accepted the appointment as case committee doctor for the Rock County Easter Seal Society.

94th Birthday for Dr. Beebe

Dr. Spencer D. Beebe, Sparta, recently observed his 94th birthday at a family party in his honor. A graduate in 1896 from Rush Medical College, Chicago, Ill., Doctor Beebe practiced five years in Elroy before going to Sparta. He was chosen "Country Doctor of the Year" in 1950 and was honored at a community celebration in 1953.

Dr. Yost Attends Meetings

Dr. R. G. Yost, Manitowoc, attended the International Medical Assembly of the Interstate Postgraduate Medical Association of North America, held in Chicago in October. He also attended the 24th Annual Meeting of the American Fracture Association held in Miami, Fla., in November.

Dr. Murphy Heads Bloomer Hospital Staff

Dr. Paul Murphy, Bloomer, was elected head of the medical staff at Memorial Community Hospital, Bloomer, in November. *Dr. M. W. Asplund*, Bloomer, was elected vice-president, and *Dr. C. T. Clauson*, Bloomer, was elected secretary. *Dr. D. F. Hudek*, Bloomer, was named liaison agent to represent the staff at hospital board meetings.

Dr. Eckberg Joins Rice Clinic

Dr. Richard A. Eckberg has joined the Rice Clinic, Stevens Point, in general and thoracic surgery. Doctor Eckberg comes from Waterloo, Ia., where he practiced surgery the last year and a half. A native of Boone, Ia., Doctor Eckberg received his premedical training at Northwestern University and his M. D. degree from the University of Iowa, Iowa City. He spent the next five years at the University of Wisconsin Medical School as an intern, a resident in general surgery, and a fellow in thoracic surgery. He is a diplomate of the American Board of Surgery, and a Navy veteran of World War II.

Dr. Schrank Speaks on Drugs

Dr. Leonard Schrank, Waupun, spoke in November to the members of the Fond du Lac County Dental and Medical Assistants Society. He discussed new drugs and developments in the medical field.

Dr. Campbell Back from Hawaii

Dr. R. E. Campbell, Madison and Mrs. Campbell returned recently from Hawaii where Doctor Campbell served as a moderator for a panel discussion on cancer at the meeting of the Pan-Pacific Surgical Association. He is professor of gynecology and obstetrics at the University of Wisconsin Medical School.

Dr. Chancey Speaks at Seminar

Dr. Robert Chancey, Beloit, spoke at an all-day seminar on "The Heart Patient and Industry" held in December at Beloit College. Doctor Chancey explained why the cardiac patient can and should work. Doctor Chancey is a graduate of Emory University Medical School and a member of the American Heart Association. He is also a fellow of the American College of Physicians.

Dr. Rupple Certified

Dr. James H. Rupple, Fond du Lac, recently was certified as a diplomate of the American Board of Ophthalmology. Doctor Rupple received his M. D. degree from Wayne State University, Detroit, in 1957. He completed his one-year general internship at Harper Hospital, Detroit, and then took his three-year residency in eye diseases and surgery at Detroit Receiving Hospital and Kresge Eye Institute in Detroit. He came to Fond du Lac in 1961 to join the staff of the Fond du Lac Clinic.

Dr. Kellogg Heads Hospital Staff

Dr. Lloyd S. Kellogg, Oregon, was recently elected president of the Methodist Hospital medical staff for 1963–1964. A member of the Oregon Clinic, Doctor Kellogg has been on the active staff of the Methodist Hospital for many years. He received his M. D. degree from the University of Illinois in 1948, after receiving a B. S. in pharmacy from the University of Wisconsin in 1942. He served his internship at the Methodist Hospital in 1948–1949.

Dr. Salibi Speaks at Seminar

Dr. Bahij Salibi, Marshfield, neurosurgeon at the Marshfield Clinic, spoke on insights into neurosurgery at the monthly (December) science seminar for high school students.

Dr. Larson Leaves Clintonville

Dr. Owen Larson, Clintonville, has closed his practice there to join *Dr. Paul Wainscott*, Menasha.

Photo courtesy of the Monroe Evening News

St. Clare Hospital, Manroe, received an Isalette far the maternity ward recently an behalf of the Green County Medical Society. Sister M. Christine is shawn here accepting the equipment from *Dr. Wayne J. Fencil*, Monrae, president af the Saciety. Maney to purchase the unit came from immunization clinics held in Green County and the Saciety agreed the fund shauld be used ta benefit the community.

Doctor Larson had served as health officer of Clintonville since 1954 and is also a past president of the Clintonville Community Hospital.

Dr. Lauvstad Joins Marshfield Clinic

Dr. Walter A. Lauvstad, an orthopedic surgeon, has joined the Marshfield Clinic, raising to 55 the number of physicians on the staff. Doctor Lauvstad was born in Corning, Ia., graduated from Drake University, Des Moines, in 1952, and from the State University of Iowa Medical School in 1958. He interned at Iowa Methodist Hospital, Des Moines, and from 1959 to September 1963 has specialized in orthopedic surgery while in residency at the Mayo Foundation, Rochester, Minn.

Dr. Pfeifer Honored

Dr. F. J. Pfeifer, New London, was presented a 50-year certificate of membership as a Royal Arch Mason and a 50-year gold Royal Arch emblem by the New London Royal Arch Masons in November. Doctor Pfeifer has served the community for more than 50 years as a physician and surgeon.

Kennedy Memorial Laboratories Dedicated

U. S. Senator Edward M. Kennedy, was in Madison in November for the dedication of the Joseph P. Kennedy Memorial Laboratories in the University of Wisconsin Medical Center. Also representing the Kennedy family was R. Sargent Shriver, director of the Peace Corps and brother-in-law of the senator. The newly constructed laboratories were built with support of a $255,000 grant from the Kennedy Foundation and additional grants from the National Institutes of Health and the Wisconsin Alumni Research Foundation.

Photo courtesy of the Ladysmith News

Dennis Siska, Hawkins high school senior class president, is shown handing *Dr. Ralph Bennett*, Ladysmith, a box of medical questions from students at a class meeting in November. The senior class is enrolled in a Medical Self Help Training course. Doctor Bennett showed a film and spoke to students on the need for knowledge and morals to prevent disease. Seated at the table are Jan Flury, physical education instructor, and Mineriva Jipson, home economics instructor at Hawkins, who conduct the course for the seniors.

Dr. Kristensen Named Chief of Staff

Dr. Lowell Kristensen, Rice Lake, has been named chief of the medical staff for Lakeside Hospital, Rice Lake, for the 1964 year. He succeeds *Dr. N. A. Eidsmoe*, Rice Lake. Doctor Kristensen, a graduate of the Yale University School of Medicine, began practice in Chetek in 1955 and came to Rice Lake in 1960 to be associated with *Drs. James F. Maser* and *Lloyd R. Cotts*. Doctor Kristensen has previously served as chief of staff at Lakeside in 1960 and as president of the Barron–Sawyer–Washburn–Burnett County Medical Society in 1961. Other members elected for 1964 are *Dr. Joseph Powell*, Chetek, as vice chief of staff; and *Dr. M. E. Gillespie*, Rice Lake, as secretary.

Dr. Simenstad Certified

Dr. Paul Simenstad, Osceola, was recently certified by the American Board of Internal Medicine.

Dr. Siebert Receives Jaycee Award

The Baraboo Chapter of the Jaycees recently selected *Dr. J. T. Siebert* as Baraboo's Outstanding Young Man of 1963. The event is one which has been carried on for many years in most chapters across the nation. Doctor Siebert is a native of Baraboo and received his M.D. from the University of Wisconsin Medical School in 1955. He served in the Army and was discharged in 1958 with the rank of captain, after which he returned to Baraboo to practice. In 1960 he was chairman of the March of Dimes drive in Sauk County, and in 1961 he was president of the Sauk County Medical Society. He has been chief of the medical staff of the Baraboo Hospital and was recently elected president of the Sauk County Chapter of the American Cancer Society.

Dr. Siebens Appointed to Committee

Dr. Arthur A. Siebens, Madison, professor of pediatrics and physiology at the University of Wisconsin Medical School, was recently appointed to the Johns Hopkins National Resources Committee, a committee established to strengthen the development activities of the university.

Dr. Cahill Becomes Medical Director

Dr. Charles A. Cahill, Milwaukee, has assumed the duties of medical director of the Winnebago County Guidance Center. He received his medical training at Harvard and served his internship at the University of North Carolina. He received his resident training at the Menninger Foundation, Topeka, Kan., and Bellevue Hospital, New York. While serving in the U. S. Navy for two years, Doctor Cahill was a psychiatrist at St. Albans Naval Hospital. He is certified by the American Board of Psychiatry and Neurology and is also medical director of the Racine County Mental Health Clinic.

Dr. Rice Addresses Rotarians

Dr. Raymond L. Rice, Milwaukee, addressed the Manitowoc Rotary Club in December and told them that 54 per cent of all American deaths are from heart disease. Doctor Rice is an assistant clinical professor of medicine at Marquette and immediate past president of the Wisconsin Heart Association.

Dr. Tenney Speaks

Dr. H. Kent Tenney, Madison, chairman of the Governor's Advisory Committee on Mental Health of Wisconsin, was the principal speaker at the annual dinner meeting of Fond du Lac county chapter of the Mental Health Association held in November.

He also gave the final lecture in the series, "Guiding Your Child—The First Five Years," at the Madison Vocational School in November.

Dr. Hansel to Baraboo

Dr. Robert G. Hansel has recently located in Baraboo. He is a graduate of the University of Iowa College of Medicine and has completed a fellowship in kidney disease at Cook County Hospital and Illinois Research and Educational Hospital, Chicago. Doctor Hansel served his internship at Milwaukee County General Hospital and took his residency in general practice in Milwaukee County General Hospital and Milwaukee Emergency Hospital.

Dr. Liewen Speaks on Firearms

Dr. B. E. Liewen, Fond du Lac, was guest speaker recently at the First Baptist Church Men's Fellowship meeting in Fond du Lac. He spoke on "Antique Firearms in America and Their Significant Contribution." He also gave a demonstration of firearms.

Dr. Hildebrand Attends Conference

Dr. J. F. Hildebrand, Sheboygan, attended the annual conference of the American Academy of Dermatology held in Chicago in December.

Dr. Hirschboeck New VP at Marquette

Dr. John S. Hirschboeck, dean of the Marquette University School of Medicine since 1947, has been named to the new office of vice-president and secretary of the medical school. In his new position, Doctor Hirschboeck will assist Father William F. Kelley, S. J., president of Marquette and of the medical school, in expediting activities of the medical board of directors and its committees. He will also represent the school in local and national public affairs, seek support for its programs, and serve on liaison committees with affiliated hospitals.

Marquette Grants

Grants totaling $513,958 for specific research, research training and medical projects were accepted by the board of directors of the Marquette University School of Medicine between September 21 and December 13, 1963. The largest was for $286,874 to *Dr. W. W. Engstrom* and Dr. E. J. Lennon of the department of medicine for continuing support of the Clinical Research Center at Milwaukee County General Hospital. It came from the U. S. Department of Health, Education and Welfare. The total in grants received by the medical school in the last six months of 1963 is $2,021,844.

UW Opens Radiotherapy Center

The University of Wisconsin Hospitals has opened its newly remodeled and expanded Radiotherapy Center at the Medical Center in Madison. Costs totaled over $450,000, not including new equipment. According to *Dr. Halvor Vermund*, Madison, director of the Radiotherapy Center, the new location will lead to better and more comprehensive studies and treatment of patients. A second purpose of the center is to develop a unit in which research and training can be provided in the field of radiotherapy of cancer.

Dr. Fruchtman Certified

Dr. Martin Z. Fruchtman, Waukesha, was recently certified by the American Board of Internal Medicine. Doctor Fruchtman received his M. D. degree from the University of Minnesota Medical School in 1956. He interned for one year at Milwaukee County Hospital, and then spent two years in military service. Doctor Fruchtman served a three-year residency at Henry Ford Hospital, Detroit, Mich., and in 1962 associated with *Drs. William Merkow* and *Aaron Sweed*, Waukesha, in the practice of internal medicine and allergy.

Dr. Pechous Wins Stritch Award

Dr. Charles E. Pechous, Kenosha, received the 1963 Stritch Medal at the annual award dinner of the Stritch Medical School of Loyola University, Chicago, Ill. The citation naming Doctor Pechous, a 1925 graduate of the school, said he had given "a lifetime of devotion and painstaking care . . . to his patients, treating each with compassion and recognition of his needs individually and as a member of his family." Doctor Pechous is a native of Chicago; he first went to Kenosha as a minor league professional baseball player. He decided to practice medicine there after completing his internship at Cook County Hospital, Chicago. He is a past president of the Kenosha County Medical Society and a past councilor of the State Medical Society. The dinner itself was a $250 a plate affair to raise money for the medical school. Mrs. Clare Booth Luce, former U. S. ambassador to Italy, was the main speaker.

Courtesy of the Kenosha News

C. E. Pechous, M.D.

Dr. Howard Joins Dr. Keepman

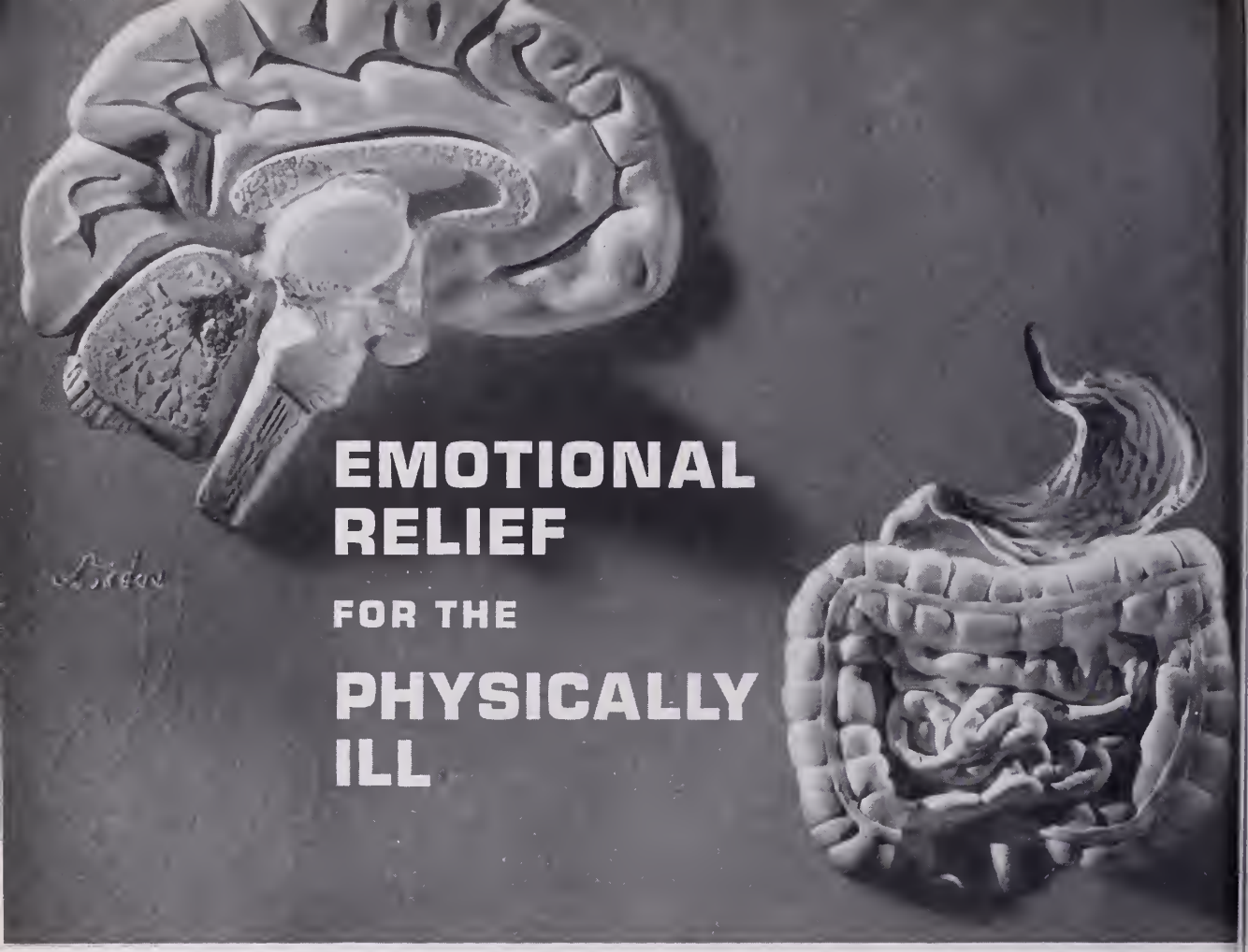
Dr. Jay P. Keepman, Madison, has announced the association of *Dr. D. Robert Howard* in general practice and obstetrics at Doctors Park, Madison.

Pathologist Joins St. Catherine's

Dr. Harold Wagner, chief coroner's pathologist of Cook County, Ill., for the past three and one half years, has been appointed associate pathologist on the medical staff of St. Catherine's Hospital, Kenosha. Doctor Wagner will be associated with Dr. Hugh Wilson, Kenosha.

Photo courtesy of the Kenosha News

Doctor Pechous is shown above, right, receiving the 1963 Stritch Medal from the Very Rev. James F. Maguire, S. J., president of Loyola University, Chicago. At center is Mrs. Clare Boothe Luce, speaker for the Stritch dinner.



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. . . keeps the patient calm, and the mind clear.

All night too

. . . aids restful sleep, with no barbiturate hangover.

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(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

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Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CMC-805

WALLACE LABORATORIES *Cranbury, N. J.*

"Art of Medicine" Has New Meaning for the CES Foundation

■ THE "art of medicine," a phrase which normally describes that part of medical practice which goes beyond the scientific elements, has taken on a new meaning for the Charitable, Educational and Scientific Foundation of the State Medical Society.

Starting with the acquisition of two works of art in connection with the Museum of Medical Progress, the Foundation's collection has grown until it now includes 25 pieces, some of them by an internationally known artist.

Actually, medicine and art have been closely associated since their beginnings. Early Egyptian art forms give us some of the first medical records. While the Foundation collection doesn't contain any samples of heiroglyphics, it does include a wide variety of art forms—oil paintings, water colors, metal point sculpture, wood carvings, etching, and dioramas.

The collection includes a widely known series of oils on historic medical developments by Aaron Bohrod, artist in residence at the University of Wisconsin. The internationally famous artist was commissioned to do the paintings by Eli Lilly and Company of Indianapolis, Indiana, and they were presented to the Foundation by the pharmaceutical firm.

Aaron Bohrod

Painted in Bohrod's "fool the eye" style, the works are entitled *Cardiology, Pediatrics, Hematology, Gastroenterology, Infectious Diseases, Neurology-Psychiatry,* and *Salt Metabolism.*

Bohrod's works hang in the permanent collections of the major art galleries in the country, and he is

Gastroenterology

Salt Metabolism

Neurology–Psychiatry

Hematology

Pediatrics

Infectious Diseases

Cardiology

Beaumont's Birthplace in oil

perhaps best known to the public for his series of covers for TIME magazine and illustrations on religious groups in America for LOOK magazine. He is credited with having more honors and awards and more representation in art galleries than any other painter of his age in the country.

Development of the Foundation's collection of art began about five years ago. In collecting materials in preparation for the opening of the Museum of Medical Progress in Prairie du Chien, two works of art were donated as part of the memorabilia of William Beaumont, M.D., pioneer military physician honored at the museum.

Aesculapian Staff in metal paint

Beaumont Bas-Relief wood carving

The first was an oil by Frederick W. Roberts, M.D., New Haven, Connecticut, depicting the birthplace of Doctor Beaumont in Lebanon, Connecticut. The painting was presented to the Foundation by the Connecticut State Medical Society.

The second is an etching of Beaumont's birthplace donated by Mrs. Eunice T. Mills of Pine Orchard, Conn. The etching was done by Herbert Thoms, M. D., who was Mrs. Mills' physician.

Other pieces in the collection also have a historical background. A bas-relief of Beaumont conducting one of his experiments was presented to the Foundation by Mrs. D. B. Dana, Ephraim, widow of a physician. The wood carving, commissioned by Doctor Dana for the 100th anniversary of the State Medical Society in 1941, is the work of a Czechoslovakian wood carver named Robert Petscheider. It hung in the Beaumont Hotel in Green Bay for 12 years prior to presentation to the Foundation.

Also related to the Beaumont theme are two of five water colors presented by the American Medical Association. All were commissioned from contemporary American artists for use on the cover of TODAY'S HEALTH. The other three represent *Doctors of the Revolutionary War, Spanish Doctors in the Old Southwest,* and *Doctors of the Airwaves*—the latter including Doctors Casey and Kildare and their current television colleagues.

One of the most unusual pieces in the collection is a metal point sculpture of the Aesculapian staff created by Robert D. Ferrell, M.D., Hempstead, New York. A three dimensional effect is achieved by driving nails of different size and color into wood. The work won recognition at a 1961 exhibition of the American Physicians Association in New York prior to its presentation to the Foundation.

Mrs. J. D. Leahy, wife of a Park Falls physician, recently presented the Foundation with an outstanding oil painting of the Aesculapian staff which she created.

Also unique are a series of five dioramas depicting significant events in the history of medicine. Portrayed in accurate detail are the first successful

Surgeon's Dilemma

Kidney Stones

First Year

removal of an ovarian tumor by Ephraim McDowell, M.D.; the first gynecologist, James Marion Sims, M.D.; the "father of American surgery," Philip Syng Physick, M.D.; the famous Wisconsinite, John B. Murphy, M.D., conducting one of his clinics; and John Collins Warren, M.D., using ether for the first time in a surgical operation.

The miniature scenes of historical surgical milestones were originally created for showing at the 1933 World's Fair in Chicago. They were on exhibition at the Museum of Science and Industry in Chicago until 1961 when they came to the Foundation as a gift of the American College of Surgeons.

Most recent additions to the collection are original oils by two physicians and the wife of a physician, all from Milwaukee. They are *First Year* by Chase W. Wolfe, M.D., *Surgeon's Dilemma* by John Erbes, M.D., and *Kidney Stones* by Mrs. Edward Jacobson. The three oils were shown at the Medical Art Salon sponsored by the Woman's Auxiliary at the Society's annual meeting in May prior to presentation to the Foundation.

First Gynecologist diorama

TODAY'S HEALTH covers

Wisconsin Licentiates

FOLLOW-UP OF PHYSICIANS PREVIOUSLY NOT LISTED AS LICENSED

The following physicians were granted licenses by written examination at a meeting held by the Wisconsin State Board of Medical Examiners, January 10–12, 1961.

Name	*School of Graduation*	*Year*	*City*
Blink, Donald V.	University of Wisconsin	1960	Minneapolis, Minn.
Felker, James R.	Marquette University	1960	St. Paul, Minn.
Kelertas, Julius H.	University of Wuerzburg	1951	Eau Claire
Santilli, Dennis M.	University of Wisconsin	1960	Broadview, Ill.

The following physicians were granted licenses by reciprocity at a meeting held by the Wisconsin State Board of Medical Examiners, January 11, 1961.

Hamilton, Charles H.	Tufts Medical School	1956	Milwaukee

The following physicians were granted licenses by reciprocity at a meeting held by the Wisconsin State Board of Medical Examiners, April 14, 1961.

Corliss, Robert J.	Jefferson Medical College	1959	Madison
May, John A.	University of Iowa	1960	Baldwin

The following physicians were granted licenses by reciprocity at a meeting held by the Wisconsin State Board of Medical Examiners, July 12, 1961.

Baker, John B.	University of Buffalo	1955	Milwaukee
Flanary, Lawrence M.	Marquette University	1956	Wood
Gannon, Paul G.	Marquette University	1954	Rochester, Minn.
Harris, John A.	Marquette University	1960	Milwaukee
Kaldahl, Paul E.	University of Oklahoma	1960	Wauwatosa
Litton, Murray A.	Medical Academy Duesseldorf	1953	Rhinelander
Mannis, Kent S.	University of Wisconsin	1960	Sparta
O'Brien, William A.	University of Dublin	1952	Iowa City, Iowa
Opitz, John M.	University of Iowa	1959	Madison
Parker, Peter E.	Ohio State University	1960	Milwaukee
Pearson, C. Arthur	University of Rochester	1960	Milwaukee
Potos, William B.	Marquette University	1960	Milwaukee
Reed, William H.	Northwestern University	1954	Watertown
Sherman, Miriam	New York University	1960	Madison
Weston, Carl B.	University of Pennsylvania	1960	Madison
Wilson, Stuart D.	University of Illinois	1960	Wauwatosa
Ziebert, Anthony P.	Marquette University	1960	Wauwatosa

The following physicians were granted licenses by written examination at a meeting held by the Wisconsin State Board of Medical Examiners, July 11–13, 1961.

Chap, Eugene J.	Marquette University	1961	Olean, New York
Gregor, Bozidar (Robert)	University of Lagreb	1953	Oconomowoc
Kienzle, Charles J.	Marquette University	1961	Milwaukee
Matty, Bela J.	University of Munich	1947	Pt. Arthur, Ontario
McNulty, Thomas B., Jr.	Marquette University	1960	Delafield
Purtell, Robert F., Jr.	Marquette University	1961	Milwaukee
Wadina, Gilbert S.	Marquette University	1961	Milwaukee

The following physicians were granted licenses by reciprocity at a meeting held by the Wisconsin State Board of Medical Examiners, October 20, 1961.

Helpenstell, Frederick	University of Illinois	1956	Waukesha
Jurczyk, Willibald	Frankfurt University	1955	Milwaukee
Sherman, Lawrence	New York University	1960	Madison

The following physician was granted a license by written examination at a meeting held by the Wisconsin State Board of Medical Examiners, January 9–11, 1962.

Pratt, Mary V.	University of Wisconsin	1961	Beloit

The following physicians were granted licenses by reciprocity at a meeting held by the Wisconsin State Board of Medical Examiners, January 10, 1962.

Name	*School of Graduation*	*Year*	*City*
Bilbo, Richard E.	University of New York	1955	Madison
Eugenio, Marco T.	University of Venezuela	1951	Houston, Texas
Harned, Roger K.	University of Virginia	1961	Shawano
Manhart, Richard A.	Ohio State University	1960	Milwaukee

The following physicians were granted licenses by reciprocity at a meeting held by the Wisconsin State Board of Medical Examiners, July 11, 1962.

Cooper, George N., Jr.	Seton Hall College of Medicine	1961	Milwaukee
Cusack, James D.	University of Illinois	1961	Wisconsin Dells
Dooley, John E.	Marquette University	1954	Milwaukee
Dougherty, John	Creighton University	1955	Sioux City, Iowa
Fry, John R.	University of Wisconsin	1959	Black River Falls
Groessl, Peter J.	Marquette University	1961	Milwaukee
Hoelscher, Kenneth	Marquette University	1961	Milwaukee
Isom, Robert G.	Marquette University	1961	Milwaukee
Konetzki, Wayne	University of Illinois	1961	Milwaukee
Nelson, Leo K.	University of Minnesota	1961	St. Croix Falls
Orn, Duane L.	University of Minnesota	1959	Turtle Lake
Papendick, David E.	Loma Linda University	1961	Algoma
Petersen, Robert J.	Washington University	1956	Scott AFB, Illinois
Rodey, Glenn E.	Ohio State University	1961	Wauwatosa
Rosenzweig, David Y.	Wayne State University	1957	Milwaukee
Siverhus, William J.	University of Minnesota	1961	Madison
Tobin, Joseph N.	Boston School of Medicine	1946	Eau Claire
Torbey, Peter	Montpellier, France	1954	Madison

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, October 26, 1962.

Belson, Michael J.	Marquette University	1960	Chicago, Ill.
Bentson, John R.	University of Wisconsin	1961	Madison
Berkey, Barry R.	University of Pittsburg	1961	Madison
Bianchin, James T.	University of Illinois	1961	Milwaukee
Bloodworth, J. M. B., Jr.	Emory University	1948	Madison
Clark, Ralph A.	University of Michigan	1958	Elm Grove
Corbert, Roland H.	Hahnemann Medical College	1946	Brookfield
Dohnalek, Donald W.	University of Iowa	1949	River Falls
Doubrava, Sterling, Jr.	University of Buffalo	1959	Milwaukee
Easom, Harry A.	University of Michigan	1958	Grosse Point, Mich.
Ecklund, LeRoy A.	Northwestern University	1956	Madison
Edgar, Robert E.	Indiana University	1955	Madison
Fitzpatrick, Paul J.	Marquette University	1961	Milwaukee
Flint, Charles H.	Columbia College of Physicians & Surgeons	1937	Minocqua
Francis, Robert J.	Marquette University	1960	Madison
Gammell, Gerald	University of Minnesota	1961	Madison
Gerdes, John A.	University of Illinois	1961	Wittenberg
Hart, Audrey F.	University of Mississippi	1961	Madison
Ho, Shu Kang	National Medical School	1947	White Bear Lake, Minn.
Hussey, Clara V.	Marquette University	1961	Milwaukee
Jordahl, Clarence, Jr.	Albany Medical College	1954	Wauwatosa
Kloehn, Roger W.	Marquette University	1961	Milwaukee
Krawitt, Edward	Cornell University	1959	Sheboygan
Lees, Jack R.	Northwestern University	1956	Marshfield
Lenartz, Henry F.	Marquette University	1959	Imperial Beach, Cal.
Levinson, Howard	University of Illinois	1961	Milwaukee
Lewis, Amelia C.	University of New York	1961	Madison
Long, Robert W.	Marquette University	1961	Manitowoc
Madsen, Paul O.	University of Copenhagen	1952	Madison
Madsen, Renate	Heidelberg University	1955	Madison
Manhart, Harold	Ohio State University	1956	Madison
Maurer, William	Marquette University	1961	Grafton
McFadden, Wayne	Ohio State University	1954	South Milwaukee
McGranahan, Thomas T.	University of Cincinnati	1957	Milwaukee
Meloy, Gisela	University of Marburg	1947	Milwaukee
Miller, Herbert P.	University of Iowa	1921	Rock Island, Ill.
Mills, E. Grady	Washington University	1953	Oconomowoc

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
O'Boyle, Robert F.	Northwestern University	1956	Appleton
Schultz, William F.	University of Tennessee	1961	Kiel
Sewell, Robert H.	University of Illinois	1959	West Allis
Stobbe, Juergen	University of Louisville	1959	Rochester, Minn.
Stobbe, Knud	University of Louisville	1959	Rochester, Minn.
Turner, C. Randolph	University of Tennessee	1953	Milwaukee
Vigario, Gordon	Jefferson Medical College	1961	Madison
Vinje, Edmund G.	Northwestern University	1939	Hazen, N. D.
Wachtel, Jacob	University of Vienna	1933	Birmingham, Ala.
Wald ,Donald H.	Creighton University	1958	Milwaukee
Wood, Charles F.	University of Leeds	1954	Iola
Young, Ronald C.	University of Minnesota	1958	St. Paul, Minn.

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, January 9, 1963.

Berman, Merle M.	Ohio State University	1958	Milwaukee
Bramschreiber, Jerome	University of Cincinnati	1959	Cincinnati, Ohio
Burkholder, Dayton	University of Pennsylvania	1958	Menomonie
Cherry, James D.	University of Vermont	1957	Madison
Deschler, William	University of the Reigh	1944	Milwaukee
Economus, Peter	University of Chicago	1961	Madison
Greenfield, Bruce	University of Florida	1960	Beloit
Keller, Theodore	Marquette University	1961	Milwaukee
Lehrman, Arthur	Albany Medical College	1958	Milwaukee
Levinson, Bernard	University of Rochester	1952	Milwaukee
Marr, V. C.	University of Heidelberg	1948	Estelline, S. D.
Schroeder, Thomas A.	University of Iowa	1959	Milwaukee
Shriber, William H.	Ohio State University	1957	Vallejo, Cal.
Siedenburg, Richard	St. Louis University	1943	Jefferson
Tonkens, Samuel	Chicago Medical School	1937	Elgin, Ill.
Wiarda, Roy J.	New York University	1949	Kenosha

The following physicians were granted licenses by written examination by the State Board of Medical Examiners at a meeting in Madison, January 8, 9, 10, 1963.

Austad, William Russell	University of Wisconsin	1962	Flint, Mich.
Blain, Claude A.	University of Ottawa	1957	Madison
Brewer, Fred F., Jr.	University of Wisconsin	1960	Lewisburg, Pa.
Burgermeister, George	University of Wisconsin	1962	Portland, Oreg.
Burns, Charlotte Ann	University of Wisconsin	1962	Madison
Clemons, John Edward	University of Wisconsin	1962	La Crosse
Cline, David William	University of Wisconsin	1962	La Crosse
Cohen, Marcus	University of Wisconsin	1962	San Francisco, Cal.
Daentl, Donna L.	University of Wisconsin	1962	Madison
Deocampo, Escolastico D.	Manila Central University	1953	Cleveland, Ohio
Eckrich, Jerome A., Jr.	Marquette University	1958	Brookfield
Eggman, Lynn D.	University of Wisconsin	1962	Madison
Eselius, Erik P.	Marquette University	1962	Grantsburg
Feldstein, Charles S.	University of Wisconsin	1962	Marinette
Gurkow, Helen Jean	Marquette University	1962	Madison
Harn, Richard Forrest	Marquette University	1962	West Bend
Higgins, Gerald L.	Loyola University	1962	Madison
Hollander, Edward M.	University of Wisconsin	1962	Toledo, Ohio
Joo, Patricia Ann	University of Wisconsin	1961	Madison
Kiselow, Mark Charles	University of Wisconsin	1962	Racine
Knezevic, Ivan	University of Belgrade	1958	Milwaukee
Korbitz, Robert F.	University of Wisconsin	1962	Madison
Linden, Robert Edward	Northwestern University	1960	San Diego, Cal.
Link, Edward Alexander	Marquette University	1962	Sidney, Ohio
Luedke, Donald Max	University of Wisconsin	1962	Brookfield
Lulloff, Kim H.	Marquette University	1960	Dodgeville
Marden, Philip Manuel	University of Wisconsin	1962	Minneapolis, Minn.
Martens, William E.	University of Wisconsin	1962	Wauwatosa
McGill, Michael W.	New York University	1961	Madison
Miller, Charles H., III	University of Wisconsin	1962	Markesan
Murphy, Raymond J.	University of Wisconsin	1962	Green Bay
Nichol, Kathryn Piziali	University of Wisconsin	1962	Madison
Nuesse, William E.	University of Wisconsin	1962	Madison

Name	*School of Graduation*	*Year*	*City*
Petasnick, Jerry P.	University of Wisconsin	1962	Forest Park, Ill.
Peterson, Lowell F.	University of Wisconsin	1962	Scandinavia
Raymond, Lou August	University of Wisconsin	1962	Sun Prairie
Sablay, Nonito M.	University of Santotomas	1956	Elkhorn
Schroeder, Norman C.	University of Wisconsin	1962	Madison
Schwartz, Herschel M.	University of Wisconsin	1961	Eloise, Mich.
Smith, Harold E.	University of Wisconsin	1962	Clinton
Stewart, William C.	Marquette University	1962	Duluth, Minn.
Strang, David J.	University of Wisconsin	1962	St. Paul, Minn.
Van Dreel, Richard Alan	University of Wisconsin	1962	Tahlequah, Okla.
Wolf, Dennis E.	University of Wisconsin	1962	Fort Yates, S. D.
Zakov, Nikola	University of Sofia	1936	Cleveland Heights, Ohio

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 19, 1963.

Adamski, Val Dennis	Marquette University	1962	Chicago, Ill.
Adornato, Samuel G.	Ohio State University	1959	Milwaukee
Backwinkel, Klaus D.	University of Munich	1953	Madison
Barbee, Robert A.	University of Chicago	1958	Madison
Bravo-Fernandez, Enrique	Johns Hopkins University	1942	Madison
Coverdale, Philip, Jr.	Marquette University	1962	Milwaukee
Cox, George Robert	New York University	1961	Madison
Criswell, David K.	Northwestern University	1959	Beloit
da Costa, Wanir C.	University of Rio de Janeiro	1955	La Crosse
de Riverio, Alfredo	University of Ascuncion	1954	Milwaukee
Fletcher, Fred W.	University of Iowa	1956	Marshfield
Freedman, Lester	Queen's University of Belfast	1961	Madison
Fuller, John Riess	University of Vermont	1946	Monroe
Gemmill, W. David	Ohio State University	1959	Menasha
Gerndt, Harold L., Jr.	University of Iowa	1958	Manitowoc
Gersch, George P.	Marquette University	1961	West Salem
Gillespie, Malcolm E.	University of Nebraska	1961	Rice Lake
Greenblatt, Melvin	Chicago Medical School	1955	Broadview, Ill.
Hart, Terrence N.	Ohio State University	1962	Wauwatosa
Hughes, Arthur B.	St. Louis College	1925	Manitowoc
Inglis, William H.	University of Minnesota	1950	Redwood Falls, Minn.
Jacobi, Donald Emil	University of Michigan	1957	Milwaukee
Kale, Waman M.	Medical College of Nagpur	1952	Richmond, Va.
Kiser, Joseph C.	University of Chicago	1957	Madison
Kraunz, Robert Frank	University of Rochester	1961	Madison
Larson, Sanford J.	Northwestern University	1954	Wauwatosa
Leigh, Carl G.	Northwestern University	1956	Chicago, Ill.
Lemann, Jacob, Jr.	University of Buffalo	1954	Milwaukee
Messinger, Paul S.	Johns Hopkins University	1957	Milwaukee
Navratil, Donald R.	University of Minnesota	1943	Milwaukee
Nirschl, Robert P.	Marquette University	1958	Rochester, Minn.
Olejnik, Waclaw	University of Gent	1954	Winnebago
Olson, Donald R.	University of Wisconsin	1961	Reno, Nev.
Polacheck, Larry J.	University of Wisconsin	1959	Fort Campbell, Ky.
Popovich, Dragojla	University of Belgrade	1939	Anoka, Minn.
Quintero, Jose M.	Havana University	1934	Morgantown, W. Va.
Remus, Cesar J.	University of Puerto Rico	1956	Wood
Roling, Gerald T.	Marquette University	1960	Zion, Ill.
Segal, Allen T.	University of Texas	1962	Madison
Sisk, James A.	University of Iowa	1958	Iowa City, Iowa
Sobel, Michael V.	Albert Einstein University	1961	Madison
Testor, James V.	University of Minnesota	1953	Winona, Minn.
Vogel, Kenneth E.	Tulane University	1960	Milwaukee
Walker, Frank A.	McGill University	1959	Madison

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 10, 1963.

Andersen, John T.	University of Minnesota	1961	Madison
Aronow, Cedor B., II	St. Louis University	1962	Rice Lake
Backer, Gordon L.	University of Minnesota	1955	Wausau
Baker, Charles S.	University of Illinois	1959	Janesville
Bryan, Albert Rahr	McGill University	1960	Milwaukee
Clifford, Richard M.	Marquette University	1962	Milwaukee
Coombs, Guerdon J.	University of Rochester	1958	Marshfield
Cortell, Stanley	Tufts University	1961	Madison
Darien, Gholi G.	Marquette University	1962	Milwaukee
Darling, Ronald J.	Marquette University	1962	Milwaukee

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
Dedmon, Robert E.	Indiana University	1956	Chicago
Delfs, Eleanor	Johns Hopkins University	1935	Milwaukee
Dempsey, Kenneth J.	University of Missouri	1962	Milwaukee
Dimlich, Stephen H.	Western Reserve University	1962	Milwaukee
Dunn, David K.	University of Wisconsin	1961	Elm Grove
Ehrhart, Jack T.	University of Cincinnati	1962	Milwaukee
Fons, Jerome W., Jr.	Marquette University	1962	Milwaukee
Gleichauf, John G.	University of New York	1962	Milwaukee
Graves, Maury D.	Marquette University	1962	Milwaukee
Gutstein, Naphtali	Chicago Medical School	1958	Chicago
Hayden, Donald J.	University of California	1962	Milwaukee
Hebert, Lee A.	Marquette University	1962	Milwaukee
Heidrick, William P.	St. Louis University	1960	Milwaukee
Herhahn, Frank T.	University of Nebraska	1962	Evanston, Ill.
Hickey, Robert C.	Cornell University	1942	Madison
Hofer, James W.	University of Iowa	1960	Milwaukee
Hogan, J. Patrick	Northwestern University	1962	Milwaukee
Horwitz, S. Fredric	Chicago Medical School	1962	Milwaukee
Kallas, Gerald J.	Marquette University	1962	Milwaukee
Kassis, Harry J.	Marquette University	1953	Wood
Kelly, Richard T.	Marquette University	1962	Milwaukee
King, Memee	Columbia University	1955	Madison
King, Muriel	Cornell University	1962	Madison
Kluge, Jon William	University of Illinois	1962	Milwaukee
Kreitzer, Frank V.	Marquette University	1962	Milwaukee
Kunkel, James A.	University of Oklahoma	1959	Marshfield
Levy, Donald M.	Louisiana State University	1959	Milwaukee
Locher, Charles J.	Marquette University	1962	Shorewood
Lokietz, Howard	Northwestern University	1962	Milwaukee
Mann, Robert	University of Leiden	1958	Mount Clemens, Mich.
McAdams, Brendan V., Jr.	Hahnemann Medical College	1962	Milwaukee
McAweeney, William J.	George Washington University	1959	Madison
Mehr, Michael Patrick	Georgetown University	1959	Fort Carson, Colo.
Milano, Angelo	St. Louis University	1955	Stevens Point
Milburn, Loretta	University of California	1962	Madison
Murray, Michael E.	University of Illinois	1962	Milwaukee
Peach, Richard O.	McGill University	1954	Milwaukee
Peters, John U.	Georgetown University	1959	Fond du Lac
Pier, Philip E.	University of Illinois	1962	Milwaukee
Piering, Walter F.	University of Wisconsin	1962	Milwaukee
Ridley, John E., III	Indiana University	1960	Selfridge AFB, Mich.
Sable, Morris H.	Chicago Medical School	1957	Milwaukee
Schaefer, Frederick	University of Cincinnati	1956	Menasha
Sciarrone, Francesco	St. Louis University	1956	Stevens Point
Smith, Thomas C.	Northwestern University	1962	Milwaukee
Sperry, Verne A.	Loyola University	1957	Eau Claire
Spicuzza, Salvatore A.	Marquette University	1962	Milwaukee
Steele, Thomas H.	Columbia University	1962	Madison
Stein, Paul G.	St. Louis University	1955	Milwaukee
Stolley, Paul D.	Cornell University	1962	Madison
Strebe, Kenneth L.	Marquette University	1962	Oconto Falls
Stringer, Winfred H.	St. Louis University	1960	Wauwatosa
Tasche, Conrad	Northwestern University	1959	Sheboygan
Terrner, Fred S.	University of Sheffield	1954	Green Bay
Warrick, Louis F., Jr.	George Washington University	1957	Madison
Weber, David R.	Indiana University	1962	Madison
Weeks, James H.	George Washington University	1956	Monroe
Wilkinson, Dudley E.	University of Nebraska	1948	Chippewa Falls
Winship, Daniel H.	University of Texas	1958	Milwaukee
Wohlwend, Edward B.	Iowa University	1956	Beaver Dam

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Madison, July 9, 10, 11, 1963.

Alverno, Luca	University of Genoa	1953	Milwaukee
Ansusinha, Tamnit	University of Medical Science	1957	Madison
Aprahamian, Charles	Marquette University	1962	Milwaukee
Arciniegas, Ernesto	National University of Colombia	1953	Chattahoochee, Fla.
Barnes, Robert A.	University of Wisconsin	1962	Milwaukee
Basiliere, James L.	University of Wisconsin	1962	San Francisco, Calif.
Biehl, Mark David	University of Wisconsin	1962	Madison

Name	*School of Graduation*	*Year*	*City*
Bonifer, Philip P., Jr.	Marquette University	1959	St. Paul, Minn.
Bustamante, Rodrigo A.	University of Havana	1944	Wood
Carpenter, Barbara E.	Northwestern University	1961	Milwaukee
Close, James S.	University of Wisconsin	1962	Appleton
Combs, James A.	University of Wisconsin	1962	Madison
deGuzman, Eleuterio A.	University of Santo Tomas	1957	Wausaukee
Dittrich, John P.	Marquette University	1959	St. Paul, Minn.
Gasparri, Piero G.	University of Naples	1948	Milwaukee
Hlavac, Robert J.	University of Wisconsin	1962	Waupun
Hughes, Michael C.	University of Wisconsin	1962	Cambria
Huizenga, Bernard A.	University of Wisconsin	1962	Waupun
Jacks, Williard G.	Southeastern National University	1960	Cambria
Ketelhohn, Alan F.	University of Wisconsin	1962	Cincinnati, Ohio
Knepel, Donald	Loma Linda University	1962	Janesville
Knoke, Thomas K.	University of Wisconsin	1962	East Point, Ga.
Kot, Peter A.	Marquette University	1957	Falls Church, Va.
Kraus, Edward D.	University of Wisconsin	1962	Rockville, Md.
Kutter, Ursula	University of Munich	1954	Milwaukee
Lastrilla, Rudolfo S.	University of Santo Tomas	1958	Milwaukee
Lusby, Richard A.	University of Wisconsin	1962	Hanford, Calif.
Mading, Russell F.	University of Wisconsin	1955	Rice Lake
Matus, Szlejma (Simon)	University of Cape Town	1941	Milwaukee
Monson, Duane G.	University of Wisconsin	1962	Minneapolis, Minn.
Noble, John G.	University of Durham	1948	Monroe
Olsen, Clark O.	University of Wisconsin	1962	Minneapolis, Minn.
O'Shea, James L.	Marquette University	1962	Highland Park, Ill.
Plotkin, Roger P.	University of Wisconsin	1962	Milwaukee
Qui, Felipe L.	University of Santo Tomas	1957	Milwaukee
Reynolds, Frank A.	University of Wisconsin	1960	Milwaukee
Sagle, Neil A.	University of Wisconsin	1962	Milwaukee
Schulkin, Frank R.	University of Wisconsin	1960	San Francisco, Calif.
Scott, Clarence M., Jr.	University of Wisconsin	1962	Superior
Scott, John C.	University of Minnesota	1961	Milwaukee
Sherman, David E.	University of Wisconsin	1962	Fond du Lac
Stanislawski, Yvonne	University of Wisconsin	1962	Milwaukee
Thomsen, James H.	University of Wisconsin	1962	Madison
Tierney, Jon P.	University of Wisconsin	1962	Superior
Torphy, Daniel E.	University of Wisconsin	1962	San Antonio, Tex.
Tydrich, James J.	University of Wisconsin	1962	Richland Center
Vavrin, Charles R.	University of Wisconsin	1962	Racine
Wallerius, John F.	Marquette University	1961	Milwaukee
Warren, Jeffrey L.	University of Wisconsin	1962	Villa Park, Ill.
Weinberg, Peter E.	University of Wisconsin	1961	Chicago, Ill.
Wirka, Herman W., Jr.	University of Wisconsin	1962	Madison
Wolfmeyer, Waldemar W.	University of Wisconsin	1962	Kaukauna
Zodrow, Warren W.	University of Wisconsin	1962	Milwaukee

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Madison, September 9, 10, 11, 1963.

Jurisic, Anthony	University of Zabrek	1950	Spring Valley
Tolentino, Mario G.	Manila Central University	1956	Milwaukee

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1964 **Wisconsin**

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Feb. 27–29: University of Wisconsin Postgraduate Course in Newer Concepts and Techniques in Gastrointestinal Disease, Wisconsin Center, Madison.

Feb. 29: Fifth Annual Conference of County Medical Society Officers, State Medical Society headquarters, Madison.

Mar. 4–5: Marquette University School of Medicine, department of dermatology and Milwaukee County General Hospital, Postgraduate course in Dermatology, Milwaukee County General Hospital, Milwaukee.

Mar. 17–18: Wisconsin Conference of Catholic Hospitals Convention, Coach House Motor Inn, Milwaukee.

Mar. 18–19: Wisconsin Hospital Association, Schroeder Hotel, Milwaukee

Mar. 19: Wisconsin Hospital Auxiliaries, Schroeder Hotel, Milwaukee.

Mar. 19: UW/SMS "In Depth" Teaching Program on Endocrinology, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Mar. 20: Small Hospital Seminar, Schroeder Hotel, Milwaukee.

Mar. 21: Third annual cancer conference for nurses, University of Wisconsin Medical Center's Division of Clinical Oncology and American Cancer Society, Wisconsin Division, Wisconsin Center, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

Apr. 16–17: Institute for Hospital Administrators, Trustees, and Chiefs of Staff, Milwaukee.

Apr. 17–18: Health Fads & Fallacies Conference, State Medical Society of Wisconsin, Port Edwards.

Apr. 22–24: Wisconsin Public Health Association and Middle States Branch of the American Public Health Association, joint meeting, Schroeder Hotel, Milwaukee.

Apr. 27–29: Annual session, Wisconsin State Dental Society, Milwaukee.

May 7: University of Wisconsin Medical School Field Day, Madison.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

1964 **Out-of-State**

Feb. 29–Mar. 5: International Academy of Proctology Sixteenth Annual Teaching Seminar, Deauville Hotel, Miami Beach, Fla.

Mar. 1–6: American College of Allergists Graduate Instructional Course, Twentieth Annual Congress, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Mar. 2–5: New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Mar. 2–5: American College of Physicians Postgraduate Course No. 12, Neurology for the Internist, Mayo Clinic, Rochester, Minn.

Mar. 6–12: Loma Linda University School of Medicine, Alumni Postgraduate Convention, Los Angeles, Calif.

Mar. 9–13: Postgraduate Course No. 13, The Physiologic Basis of Electrocardiography, American College of Physicians, University of Utah College of Medicine, Salt Lake City.

Mar. 16–18, 23–25: Clinical Reviews, Mayo Clinic and Mayo Foundation, Theater, Mayo Civic Auditorium, Rochester, Minn.

Mar. 16–19: American College of Surgeons, New Orleans, La.

Mar. 16–21: Fifth postgraduate course in Medical Technology, University of Colorado School of Medicine, Denver.

Apr. 6–10: American College of Physicians, Annual Meeting, Convention Hall, Atlantic City, N. J.

Apr. 13–16: American Industrial Health Conference, Pittsburgh–Hilton Hotel, Pittsburgh, Pa.

Apr. 27–29: Tri-State Hospital Assembly, 34th Annual Meeting, Palmer House, Chicago.

May 5–15: Postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," University of Cincinnati College of Medicine and Christ Hospital, Cincinnati.

May 11–14: 35th Annual Scientific Meeting of the Aerospace Medical Association, Americana Hotel, Miami Beach, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 1–5: American College of Physicians postgraduate course No. 17, "Recent Advances in Clinical Nutrition," Lemuel Shattuck Hospital, Boston, Mass.

June 8–12: American College of Physicians postgraduate course No. 18, "Recent Progress in Endocrinology," University of Washington School of Medicine, Seattle.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

Aug. 24–27: American Hospital Association, Chicago.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Oct. 26–29: National Safety Congress, Chicago.

Wisconsin Public Health Association

On April 22, 23, and 24 there will be a joint meeting of the Wisconsin Public Health Association and the Middle States Branch of the American Public Health Association in Milwaukee at the Schroeder Hotel.

Dr. James Wardlaw, Madison, of the Wisconsin State Board of Health, is the coordinator for the development of the program.

UW Medical School Field Day

The Student Affairs Committee has set Thursday, May 7, as the date for the annual University of Wisconsin Medical School Field Day, in Madison. The field day consists of speeches and scientific exhibits to help stimulate student interest in independent study and research.

Electronics in Cardiovascular Disease

A symposium on Clinical Applications of Electronics in Cardiovascular Disease will be held in Rochester, Minn., on September 10 and 11, 1964, co-sponsored by the Minnesota Heart Association and Mayo Clinic. For further information write: J.F. McCally, Secretary, Minnesota Heart Symposium, Mayo Clinic, Rochester, Minn.

UW/SMS "In Depth" Teaching Programs

The fifth University of Wisconsin Medical School and State Medical Society co-sponsored teaching programs will be held on March 19 on the topic thyroid disease. A clinic will be held from 10:00 a.m. to 12:00 n. at Wisconsin General Hospital, 1300 University Avenue, Madison. Patients will be presented for observation and discussion, with various members of the Department of Medicine, University of Wisconsin, taking part in the program.

The afternoon program, from 12:00 n. to 4:00 p.m., will be held at the State Medical Society building, 330 East Lakeside Street, and will feature Dr. F. Raymond Keating, Mayo Clinic, Rochester, Minn., as guest lecturer. Other speakers will be Dr. E. C. Albright, Dr. E. S. Gordon, Dr. F. C. Larson, and Dr. Howard Rasmussen, all of the University of Wisconsin.

Loma Linda Convention

The thirty-second Annual Alumni Postgraduate Convention, sponsored by the Alumni Association of the Loma Linda University School of Medicine, will be held in Los Angeles March 6 through 12.

Refresher courses, which will be taught by medical school faculty in the fields of surgery, internal medicine, ophthalmology, obstetrics and gynecology, pediatrics, orthopedics and narcotic testing, will be offered at the White Memorial Medical Center and the Los Angeles County General Hospital. Category I credit will be granted for these courses by the American Academy of General Practice.

The Scientific Assembly will be held at the Ambassador Hotel, in Los Angeles on March 10, 11, and 12. For more information write: Dr. Jack G. Hallatt, Alumni Association of the School of Medicine, Loma Linda University, Los Angeles 33, Calif.

National League for Nursing

Improvement of Hospital Nursing Services, National League for Nursing, will be held in four geographical locations—east, south, midwest, and west—this spring. The regional councils of State

Whether you're a teacher correcting exams. A student cramming for them. A housewife cleaning up after the kids. Or a businessman working late at night. Whoever you are, things go better when you pause and refresh with ice-cold Coca-Cola.

Leagues for Nursing are cosponsoring the series with the League's department of hospital nursing.

The series is "Blueprint for Action" and is a follow-up to the earlier "Blueprint for Progress" conferences which brought together nearly 1,000 hospital nursing service representatives in 1962.

The Midwest conferences are set for Minneapolis, Minn., April 29-May 1. Invitations to participate in the conferences are being issued to hospital administrators, directors and assistant directors of hospital nursing service, inservice education personnel, and others concerned with improving hospital nursing services and the quality of patient care. Hospitals are being asked to send two representatives to the conference in their region.

The series is designed to provide an opportunity for key hospital nursing service personnel to explore ways of achieving high quality patient care through effective leadership and acuity to the process of change, planning action to improve patient care, and exploring ways of organizing nursing service for the maximum use of available personnel and other resources.

Pre-registration is required and applications may be obtained from the Department of Hospital Nursing, National League for Nursing, 10 Columbus Circle, New York, N. Y. 10019. The fee is $50.00 for National League of Nursing members and $60.00 for nonmembers.

Cancer Conference for Nurses

The third annual Cancer Conference for Nurses, "Cancer and Care of the Patient," will be held Saturday, March 21, at the Wisconsin Center Building on the University of Wisconsin campus, Madison, from 9:30 a.m. to 4:00 p.m. It is cosponsored by the University of Wisconsin Medical Center's Division of Clinical Oncology and the American Cancer Society, Wisconsin Division.

The special guest speaker at the 12:30 luncheon will be Miss Catherine Nelson, R.N., Columbia University Teacher's College, Department of Nursing Education, New York City. Panels, discussions, and presentations on what's new in cancer control and treatment; special care in surgical, radiotherapy and chemotherapy cancer cases including nutrition and rehabilitation; cancer research trends as they affect the nurse; the nurse's role in colostomy care; the skin, its care and troubles will be made.

The registration fee is $3.00 and covers the luncheon. The chairman is Dr. R. J. Samp, Box 1626, Madison 1, Wisconsin.

U–W Postgraduate Program

The University of Wisconsin Postgraduate Program in Medical Education on "Heart Disease in Infancy and Childhood" will be held April 9–11, at the Wisconsin Center Building, corner of Lake and Langdon Street, Madison. The program has been approved by and accredited by the Academy of General Practice, and will include material on problems of current interest in the physiology, diagnosis, and management of congenital and acquired heart disease.

Registration is limited to 100 persons. The fee is $50.00, and covers tuition, materials, coffee breaks, necessary chartered transportation, and Thursday and Friday noon lunches.

Thursday's program, April 9, features "Cardiopulmonary Physiology" as a main topic in the morning with lectures and discussions correlated. The afternoon topic is "Principles of Diagnosis" with a correlated lecture and panel discussion. Thursday evening, dinner will be served at the Blackhawk Country Club, and Dr. Robert J. Lampman, professor of economics, University of Wisconsin, will speak on "Who Owns America?".

On Friday, April 10, there will be lectures on "Principles of Diagnosis in Congenital Heart Disease," and "Congestive Heart Failure in Infancy and Childhood", plus clinical groups, case examinations, and informal discussion groups.

On Saturday, April 11, the main topic will be "Acquired Heart Disease," with lecture on "Diagnosis and Management of Acute Rheumatic Fever," and a panel of acquired heart disease.

The guest faculty for the program will include: Dr. Frank Dammann, Jr., professor of surgical cardiology and pediatrics, University of Virginia Medical Center, Charlottesville, Va.; Dr. James W. DuShane, head of section of pediatrics, Mayo Clinic, professor of pediatrics, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minn.; Dr. William G. Gallen, assistant professor of pediatrics, Marquette University, Milwaukee; Dr. George G. Griese, cardiologist, department of pediatrics, Marshfield Clinic, Marshfield; Dr. Julien I. E. Hoffman, assistant professor of pediatrics and medicine, Albert Einstein College of Medicine, Yeshiva University, New York, N. Y.; Dr. Dan G. McNamara, assistant professor of pediatrics and medicine, Baylor University, College of Medicine, and chief of cardiology, Texas Children's Hospital, Houston, Tex.; and Dr. Milton Markowitz, associate professor of pediatrics, Johns Hopkins University School of Medicine, and assistant pediatrician-in-chief, Sinai Hospital of Baltimore, Baltimore, Md.

Wisconsin Work Week of Health

The Second Annual Wisconsin Work Week of Health, featuring conferences on alcoholism, mental retardation, medicine and religion and emergency care, will be held at State Medical Society headquarters in Madison, February 24–29.

The event, sponsored by the medical society, is open to the general public. There is no registration fee.

"Goal of the Work Week of Health," said Dr. W. J. Egan, Milwaukee, President of the Society, "is to provide a means for an exchange of informa-

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MEDICAL MEETINGS *continued*

tion on the health status of the state and examine the trends and philosophies which will determine Wisconsin's health in the future."

The program is shown on pages 62–63–64.

Marquette Postgraduate Course

Marquette University School of Medicine, Department of Dermatology, in co-operation with the Milwaukee County General Hospital announces a postgraduate course in "Dermatology" to be given on March 4 and 5.

The meetings will be from 8:30 a.m. to 5:00 p.m. and will be held in the Coffey Memorial Auditorium of the Milwaukee County General Hospital, 8700 West Wisconsin Avenue, Milwaukee.

The director of the course is: Dr. David W. Kersting, professor and chairman, Department of Dermatology, Marquette University School of Medicine. The American Academy of General Practice will allow 14 hours, Category I credit for the course.

The tuition is $35.00 (no charge to residents, interns, or medical students). Checks should be made payable to Marquette University School of Medicine and sent to: Dr. Joseph W. Rastetter, Director, Postgraduate Medical Education Programs, 8700 West Wisconsin Avenue, Milwaukee.

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CARE OF NEWBORN

CONFERENCES PLANNED

■ A series of seven teaching conferences for nurses and physicians on "Care of the Newborn: Including Prematurity," will be conducted in April and June under the auspices of the State Medical Society's Division on Maternal and Child Welfare, of the Commission on State Departments, and the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. The programs are presented through the CES Foundation, with supporting funds from Mead Johnson Laboratories and the State Board of Health.

Dates and meeting sites are as follows:

Wednesday, April 1: St. Francis Hospital, La Crosse

Wednesday, April 8: Holy Family Hospital, Manitowoc

Wednesday, April 15: Mercy Hospital, Janesville

Wednesday, April 22: St. Joseph's Hospital, Beaver Dam

Tuesday, June 9: Holy Family Hospital, New Richmond

Wednesday, June 10: New Memorial Hospital, Superior

Thursday, June 11: Langlade County Memorial Hospital, Antigo

The morning session, from 10 to 12 noon will be *for nurses only*, with instruction provided by Sister M. Christopher, Nursing Instructor and Supervisor in Obstetrics and Care of the Newborn at St. Mary's Hospital, Madison; and Miss Helen Callon, Hospital Nursing Consultant in Maternal and Child Health of the Wisconsin State Board of Health. Areas of instruction will include: Prevention of Infections in the Nursery, Skin Care of the Newborn, Feeding Techniques, and Equipment Used in Care of the Newborn (Demonstrations).

Afternoon Meeting For MDs

The afternoon session, from 1:30–4:30 p.m. will be directed, primarily, to physicians, although nurses attending the morning session will also be in attendance. Instruction will be provided by *Thomas V. Geppert, M.D.*, assistant clinical professor of Pediatrics at the University of Wisconsin Medical School. Topics to be covered will be: Resuscitation of the Newborn, Infant Feeding, Diseases of the Newborn, and Special Problems of Prematurity.

A.A.G.P. Credit Available

Members of the Wisconsin Academy of General Practice attending these programs will be entitled to *three hours* of educational credit.

No Fee

With supporting funds from the Bureau of Maternal and Child Health of the State Board of Health and Mead Johnson Laboratories these programs will be provided *without registration fee*, as a continuing educational service of the CES Foundation. Nurses attending the morning session will be expected to remain for lunch ($1.25 per person, paid at time of the meeting), but there is no charge for the meeting, either in the morning or afternoon. However, to plan for the afternoon coffee break and to prepare badges, *advance registration would be appreciated.* Physicians are requested to mail the slip below, indicating what meeting they plan to attend.

MAIL TO ROY T. RAGATZ: Asst. Secy, State Medical Society of Wis., Box 1109, Madison, Wisconsin 53701

I plan to attend the conference on "Care of the Newborn" as checked below:

April 1: La Crosse _____ June 9: New Richmond _____

April 8: Manitowoc _____ June 10: Superior _____

April 15: Janesville _____ June 11: Antigo _____

April 22: Beaver Dam _____

Name: _____

City: _____

SECOND ANNUAL

Wisconsin Work Week of Health

SPONSORED BY THE STATE MEDICAL SOCIETY OF WISCONSIN

February 24–29, 1964

MONDAY, FEBRUARY 24

Emergency Care by Nonmedical Personnel

Richard B. Windsor, M. D., Sheboygan, Moderator

A.M.

8:30 Registration

8:50 Greetings, *W. J. Egan, M.D.*, President, State Medical Society of Wisconsin

9:00 Artificial Respiration and Circulation, *Robert M. Senty, M. D.*, Sheboygan

9:45 Care of Localized Trauma, *N. Peter Braun, M. D.*, Sheboygan

10:30 Break

10:45 Emergency Obstetrics, *William Kiekhofer, M. D.*, Madison

11:30 Workshop Sessions: Discussion leaders: *James L. Weygandt, M. D.*, Sheboygan Falls; *Eugene E. Eckstam, M. D.*, Monroe; *Walter F. Smejkal, M. D.*, Manitowoc

12:15 Luncheon

P.M.

1:30 Legal Responsibility of the Good Samaritan, *Stephen E. Gavin*, Manager, Wisconsin Chapter, The Associated General Contractors of America, Inc., Madison

2:15 Transportation of the Injured and Safe Driving of Emergency Vehicles, *Captain John Schoenick*, State Patrol Academy, Camp McCoy

3:00 Break

3:15 The Operation of the Wisconsin Council of Safety, *Robert W. Gillette*, Executive Director

3:30 Problems in Automotive Safety Design, *Richard C. Braisted*, Head, Field Branch, Automotive Crash Injury Research, Cornell Aeronautical Laboratory, Inc., Buffalo, N. Y.

4:15 Questions and Answers: Panel of all speakers

4:30 Adjournment

TUESDAY, FEBRUARY 25

Alcoholism and Industry

Charles A. Wunsch, M. D., Green Bay, Moderator

A.M.

8:30 Registration

8:50 Greetings, *W. J. Egan, M. D.*, President, State Medical Society of Wisconsin

9:00 Alcoholism in Industry, *Henry A. Mielcarek*, Manager, Personnel Service Section, Allis-Chalmers Manufacturing Company, Milwaukee

9:45 The Medical Aspects of Alcoholism in Industry, *Sidney S. Greenberg, M. D.*, Assistant Professor of Clinical Medicine, Consultation Center for Alcoholism, New York University Medical Center, New York

10:30 Break

10:45 Profile of the Alcoholic, *Arnold S. Zentner, M. D.*, Director, Consultation Center for Alcoholism, New York University Medical Center, New York

11:30 Personal Reference, Larry M_____, a Member of Alcoholics Anonymous

12:15 Luncheon

P.M.

1:30 Utilizing Community Resources, *James S. Ray*, Administrator, Milwaukee Council on Alcoholism, Inc., Milwaukee

2:15 Legal Rights and Problems of the Alcoholic, *Robert A. Moore, M. D.*, Assistant Professor of Psychiatry, University of Michigan, Ann Arbor

3:00 Break

3:15 Courts Can Help in Rehabilitation, *Joseph R. Matejicka*, Lieutenant of Police, Milwaukee Police Department

4:00 Questions and Answers: Panel of all speakers

4:30 Adjournment

continued on next page

WEDNESDAY, FEBRUARY 26

Mental Retardation

James F. McDonald, President, The Wisconsin Council for Retarded Children, Inc., Milwaukee, Moderator

A.M.

8:30 Registration

8:50 Greetings, *W. P. Curran, M. D.*, President-elect, State Medical Society of Wisconsin

9:00 Implications for Wisconsin of the Report of the President's Panel on Mental Retardation
John W. Melcher, Director, Bureau for Handicapped Children, State Department of Public Instruction, Madison

9:45 *Harry A. Waisman, M. D.*, Professor of Pediatrics, University Hospitals, Madison

10:30 Break

10:45 *Harvey A. Stevens*, Superintendent, Central Wisconsin Colony and Training School, Madison

11:30 Questions and Answers

12:15 Luncheon

P.M.

1:30 The Community Role and Public Health Responsibility, *James L. Wardlaw, Jr., M. D.*, Director, Section on Community Health Services, State Board of Health, Madison

2:15 Retardation from the Viewpoint of the Physician, *H. Kent Tenney, M. D.*, Chairman, State Mental Health Advisory Committee, Madison

3:00 Break

3:15 Retardation—What it Means to Me, *Mr. and Mrs. John Schern*, Waukesha; *Dr. and Mrs. Matthew D. Davis*, Madison

4:00 Questions and Answers: Panel of all speakers

4:30 Adjournment

THURSDAY, FEBRUARY 27

Medicine and Religion

Arne E. Larson, Assistant Director, Department of Medicine and Religion, American Medical Association, Chicago

A.M.

8:30 Registration

8:50 Greetings, *W. P. Curran, M. D.*, President-elect, State Medical Society of Wisconsin

9:00 What the Physician Expects of the Clergy, *Donn G. Mosser, M. D.*, Director, Radiation Therapy, University of Minnesota Hospitals, Minneapolis

9:45 What the Clergy Expects of the Medical Care Team, *Rev. Granger E. Westberg*, Associate Professor, Religion and Health, The University of Chicago, Chicago

10:30 Break

10:45 My Reaction Is . . ., *Rabbi Manfred E. Swarsensky*, Temple Beth El, Madison; *Father Lawrence J. Kieffer*, St. Thomas Congregation, Potosi; and *Karl H. York*, Administrator, St. Luke's Memorial Hospital, Racine

12:15 Luncheon

P.M.

1:30 Religion and Psychiatry, *Smiley Blanton, M. D.*, Director, The American Foundation of Religion and Psychiatry, New York

2:15 We Work Together Because . . ., *Leigh M. Roberts, M. D.*, University Hospitals, Madison; *Rev. John R. Thomas*, Chaplain Supervisor, Mendota State Hospital, Madison
(Questions from the audience)

3:00 Break

3:15 "The One Who Heals"; film. Physicians confront medical problems involving faith

4:00 Adjournment

FRIDAY, FEBRUARY 28

Medical-Legal-Economic Conference

Philip S. Habermann, Executive Director, State Bar of Wisconsin, Madison, Moderator

A.M.

8:30 Registration

8:50 Greetings, *W. J. Egan, M. D.*, President, State Medical Society of Wisconsin

9:00 Taxes as They Affect Your Professional Practice, *James O. Ash*, C.P.A., La Crosse

9:45 Taxes as They Affect Your Professional Practice, *Warren H. Stolper*, Attorney at Law, Madison

10:30 Break

10:45 Partnerships—Solo Practitioners: Personal Corporations and H. R. 10, *Robert B. Throckmorton*, General Counsel, American Medical Association, Chicago; *Frederic Sammond*, Attorney at Law, Mil-

continued on next page

WISCONSIN WORK WEEK OF HEALTH *continued*

waukee; and *George T. Burrill*, C. P. A., Madison

12:15 Luncheon

P.M.

1:30 Charges for Professional Services in Litigation (Fee Schedules Between Professions), *Herbert Terwilliger*, Attorney at Law, Wausau; *E. J. Nordby, M. D.*, Madison

2:15 The Role of the CPA in the Professional Practitioner's Business, *John W. Ullrich*, C.P.A., Wausau

3:00 Break

3:15 Where Do the Professions Go From Here, *Hugh W. Brenneman*, Executive Director, Michigan State Medical Society, East Lansing

4:00 Questions and Answers: Panel of all speakers

4:30 Adjournment

SATURDAY, FEBRUARY 29

Fifth Annual Conference, County Medical Society Officers

Moderator: *James C. Fox, M.D.*, Chairman, Council of the State Medical Society of Wisconsin

9:00 REGISTRATION

10:00 GREETINGS
W. J. Egan, M.D., President, State Medical Society of Wisconsin

10:15 CURRENT PROGRAM OF THE AMERICAN HEART ASSOCIATION
J. Scott Butterworth, M.D., Past President, American Heart Association, New York City

11:15 THE UNITED FUND VERSUS VOLUNTARY HEALTH AGENCIES
Morris Fishbein, M.D., Editor, MEDICAL WORLD NEWS, New York City

12:15 LUNCHEON

1:30 HOPE—AMERICAN MEDICINE'S FINEST HOUR
William B. Walsh, M.D., President, People to People Health Foundation, Project HOPE, Washington, D. C.

2:30 OBSERVATIONS AND SUMMARY
Herman L. Toser, Insurance Director, Wisconsin Physicians Service, Madison

3:30 ADJOURNMENT

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1964 ANNUAL MEETING

Scientific Program • Preliminary Report

Working closely with the various specialty societies and the Wisconsin Academy of General Practice, the Commission on Scientific Medicine has prepared an outstanding program for the Annual Meeting in Milwaukee, May 11–12–13. To give you an opportunity of planning your attendance, the outline of the Scientific Program is included in the January and February issues of the JOURNAL. The March issue will include full details, and *around the latter part of March a special announcement on the noon scientific luncheons will be sent you.*

PLAN NOW TO ATTEND, AND MARK YOUR CALENDAR FOR THESE DATES

MONDAY, MAY 11

Featuring Obstetrics, Gynecology, and Pediatrics of importance to General Practitioners as well as Specialists in these fields.

MORNING PROGRAMS

1. **OBSTETRICS AND GYNECOLOGY . . . planned by Wisconsin Society of OB and GYN**

   Entire day program will be devoted to general subject of "Pregnancy Wastage." *Sprague H. Gardiner, M.D.* and *Richard W. Stander, M.D.*, both of Indianapolis, Ind., have agreed to participate. Details of program, topics, and additional speakers from Wisconsin will be provided later.

2. **PEDIATRICS . . . planned by Wisconsin Chapter, American Academy of Pediatrics . . . general theme: "Malignancy in Children"**

   A. LEUKEMIA IN RELATION TO GENETICS: *Wayne H. Borges, M.D.*, Chicago. Discussant: *Samuel McCreadie, M.D.*, Milwaukee

   B. CASE PRESENTATIONS ON "MALIGNANCY IN CHILDREN" provided by Departments of Pediatrics at Marquette University School of Medicine and Children's Hospital, Milwaukee. Panelists: *Wayne H. Borges, M.D.*, Chicago; *Samuel McCreadie, M.D.*, Milwaukee; *Anthony V. Pisciotta, M.D.*, Milwaukee

NOON LUNCHEONS

1. **University of Wisconsin Alumni**
2. **Marquette University Alumni**
3. **Roundtables:**

   A. THE IRONIC RETICULOCYTE: *Wayne H. Borges, M.D.*, Chicago

   B. SURGICAL EMERGENCIES IN THE NEWBORN: *Thomas Boles, M.D.*, Columbus, O.

   C. THE OBSTETRICIAN AND PREMATURITY: *Sprague H. Gardiner, M.D.*, Indianapolis, Ind.

   D. ANTENATAL PREDICTION OF ERYTHROBLASTOSIS FETALIS: *Richard W. Stander, M.D.*, Indianapolis, Ind.

AFTERNOON PROGRAMS

1. **OBSTETRICS AND GYNECOLOGY . . . continuation of morning program**
2. **PEDIATRICS . . . continuation of morning program**

   A. ABDOMINAL MASSES IN INFANT AND CHILDREN: *Thomas Boles, M.D.*, Columbus, O. Discussant: *John R. Pellett, M.D.*, Madison

   B. PANEL AND CASE PRESENTATIONS . . . cases provided by University of Wisconsin Medical School, Madison. Panelists: *John R. Pellett, M.D.*, Madison; *Donald Babbitt, M.D.*, Milwaukee; *Thomas Boles, M.D.*, Columbus, O.; *Samuel McCreadie, M.D.*, Milwaukee

EVENING PROGRAM

New Research at the University of Wisconsin and Marquette University . . . presented by the Wisconsin Society of Internal Medicine, in cooperation with the two medical schools

TUESDAY, MAY 12

Featuring Medical Genetics and its application to clinical medicine . . . plus a very practicable application of antidepressant drugs in Psychiatry.

MORNING PROGRAMS

1. **MEDICAL GENETICS: A CLINICAL FIELD . . . planned by Wisconsin Society of Internal Medicine and Wisconsin Society of Pathologists**

   A. WHAT IS "MEDICAL GENETICS"? *James Crow, Ph.D.*, Madison

   B. DNA METABOLISM AND ITS INFLUENCE ON PROTEIN SYNTHESIS: *Charles Heidelberger, Ph.D.*, Madison

   C. MECHANICS OF CHROMOSOME ANALYSIS: *Stanley Inhorn, M.D.*, Madison

   D. PANEL (TITLE PENDING): Moderator, *David Yi-Yung Hsia, M.D.*, Chicago. Participants: *James Crow, Ph.D.*, *Charles Heidelberger, Ph.D.*, and *Stanley Inhorn, M.D.*, Madison

NOON LUNCHEONS

1. **Roundtables:**

   A. JAUNDICE IN THE NEWBORN INFANT: *David Yi-Yung Hsia, M.D.*, Chicago. Official luncheon of Wisconsin Society of Pathologists, but open to all MDs.

   B. TITLE PENDING: *Arno Motulsky, M.D.*, Seattle, Wash. Official luncheon of Wisconsin Society of Internal Medicine but open to all MDs.

C. MAINTENANCE THERAPY WITH PSYCHOTROPIC DRUGS: *Burtrum C. Schiele, M.D.*, Minneapolis, Minn. Official luncheon of Wisconsin Psychiatric Association, but open to all MDs.
D. RECENT ADVANCES IN THERAPY: *Ovid Meyer, M.D.*, Madison
E. RESUME OF CONTROVERSIAL ASPECTS OF BREAST SURGERY: *Robert Hickey, M.D.*, Madison

2. CES Foundotion Annuol Meeting of Trustees ond Directors

AFTERNOON PROGRAMS

1. MEDICAL GENETICS: A CLINICAL FIELD . . . continuotion of morning progrom
   A. INBORN ERRORS IN METABOLISM: *David Yi-Yung Hsia, M.D.*, Chicago. William Beaumont Memorial Lecture sponsored by the CES Foundation
   B. CLINICAL APPLICATIONS OF MEDICAL Genetics: *Arno Motulsky, M.D.*, Seattle, Wash.
   C. PANEL (TITLE PENDING): Moderator: Pending. Participants: *David Yi-Yung Hsia, M.D.*, others pending
2. PSYCHIATRY . . . plonned by Wisconsin Psychiotric Association
   A. CURRENT PERSPECTIVES ON ANTIDEPRESSANT DRUGS: *Burtrum Schiele, M.D.*, Minneapolis, Minn. Rogers Memorial Lecture of the Rogers Memorial Hospital, Oconomowoc. Discussant: *William Heywood, M.D.*, Marshfield
   B. PANEL ON "OFFICE AND HOSPITAL USE OF TRANQUILIZING DRUGS: Moderator, *Milton Miller, M.D.*, Madison. Participants: *Earl J. Jochimsen, M.D.*, Sheboygan; *William L. Lorton, M.D.*, Wauwatosa; *Gilbert Tybring, M.D.*, Madison; and *Robert Urbanek, M.D.*, Beaver Dam

WEDNESDAY, MAY 13

Featuring Dermatology, Orthopedic Surgery, Anesthesiology, Radiology, Ophthalmology and Otolaryngology, and Surgery.

MORNING PROGRAMS

1. SPECIAL PROGRAM ON OCCUPATIONAL DERMATOSIS . . . plonned by Wisconsin Dermotological Society

   Entire program will consist of cases (with some patients presented) to discuss various facets of the problem of occupational dermatology. Guest discussant: *Donald Birmingham, M.D.*, Cincinnati, O.

   Each case will be discussed separately by:
   - A physician: The matter of diagnosis and treatment
   - A lawyer: Legal aspects of the case
   - A safety engineer
   - An insurance man

2. SPECIAL PROGRAM ON FRACTURES OF THE KNEE AND ANKLE JOINTS . . . provided by Wisconsin Society of Orthopedic Surgeons
   A. FRACTURES ABOUT THE KNEE JOINT: *Harry Hall, M.D.*, Minneapolis, Minn.
   B. PANEL: TREATMENT OF FRACTURES ABOUT THE ANKLE JOINT: Moderator: *Paul Collopy, M.D.*, Milwaukee. Participants: *Harry Hall, M.D.*, Minneapolis, Minn.; *Herman Wirka, M.D.*, Madison, and *Chester Sattler, M.D.*, Kenosha

NOON LUNCHEONS

1. Anesthesia
   A. THE DEVELOPMENT OF ATELECTASIS DURING ANESTHESIA: *Douglas Eastwood, M.D.*, Charlottesville, Va.
   B. CLINICAL HYPOTENSION WITH HALOTHANE: *Evan Frederickson, M.D.*, Kansas City
2. Dermotology
   USE AND MISUSE OF THE PATCH TEST IN THE DIAGNOSIS OF OCCUPATIONAL SKIN DISEASE: *Donald Birmingham, M.D.*, Cincinnati, O.
3. EENT
   Luncheon preceding business meeting of SMS Scientific Section, and scientific program, with *Paul A. Chandler, M.D.*, Boston, and *Jerome A. Hilger, M.D.*, St. Paul, as speakers.
4. Radiology
   RADIOLOGIC ASPECTS OF ACUTE GASTROINTESTINAL HEMORRHAGE: *Buell C. Buchtel, M.D.*, New Orleans, La.
5. Orthopedic
   THE FLEXION AND EXTENSION INJURIES TO THE NECK FOLLOWING A REAR-END AUTO COLLISION: *Harry B. Hall, M.D.*, Minneapolis
6. Phormocology
   NEW CONCEPTS IN THE DRUG THERAPY OF ANGINA PECTORIS: *Harold Hardman, M.D., Ph.D.*, Milwaukee
7. Genetics
   GENETICS—A PUBLIC HEALTH PROBLEM: *James Crow, Ph.D.*, Madison. Official luncheon of Public Health Physicians, but open to all MDs.
8. Nonscientific
   PAST PRESIDENT'S LUNCHEON

AFTERNOON PROGRAMS

1. ANESTHESIOLOGY . . . plonned by Wisconsin Society of Anesthesiologists
   A. SOME ASPECTS OF NITROUS OXIDE PHARMACOLOGY AND TOXICITY AFFECTING CLINICAL USE: *D. W. Eastwood, M.D.*, Charlottesville, Va.
   B. NOTES ON THE PRODUCTION OF ANALGESIA WITH NITROUS OXIDE: *Evan Frederickson, M.D.*, Kansas City, Kan.
2. OPHTHALMOLOGY AND OTOLARYNGOLOGY . . . plonned by the State Medical Society Scientific Section on O & O
   A. LUNCHEON
   B. BUSINESS MEETING
   C. CHOICE OF TREATMENT IN DISLOCATION OF THE LENS: *Paul A. Chandler, M.D.*, Boston, Mass. Sponsored by Milwaukee Oto-Ophthalmic Society
   D. MIDFACIAL INJURIES: *Jerome A. Hilger, M.D.*, St. Paul, Minn. Sponsored by Wisconsin Otolaryngologic Society
3. RADIOLOGY . . . plonned by Wisconsin Radiologicol Society
   A. RADIOLOGIC EVALUATION OF HYPERTENSION OF RENAL ORIGIN: *Buell C. Buchtel, M.D.*, New Orleans, La.

B. THE ROLE OF RADIOTHERAPY IN THE TREATMENT OF CANCER: *Isadore Lampe, M.D.*, Ann Arbor, Mich.
Other papers by Wisconsin MDs—see March issue.

4. SURGERY . . . planned by Wisconsin Surgical Society
Guest lecturer: *Robert Tidrick, M.D.*, Iowa City, Ia.
Balance of program will be presented by members of the Wisconsin Surgical Society, details of which will be announced later.

HOUSE OF DELEGATES

Since the Annual Meeting Scientific Program has been set ahead one day (Monday-Tuesday-Wednesday instead of Tuesday-Wednesday-Thursday, as in past years), the House of Delegates meetings have also been set ahead one day. This year the House will meet Sunday night, May 10, Monday night, May 11, and Tuesday morning, May 12.

These meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session. Old business from the October Interim Session will also be presented. Reference committees will meet Monday morning, with reports to be made at the Monday night, or second, session. Other business, including election of officers and councilors, will be held Tuesday morning, at the final session.

ANNUAL DINNER

The annual dinner will be held Tuesday evening, instead of the usual Wednesday evening, as in past years. Details of this event will appear in the March issue.

CES FOUNDATION

The Annual Meeting of the Board of Trustees of the Foundation will follow a luncheon scheduled for Tuesday noon, instead of Wednesday as in past years.

PAST PRESIDENT'S LUNCHEON

The Past President's luncheon will be held Wednesday noon, instead of Thursday as in the past, with all past presidents invited to attend. Dr. W. J. Egan, Milwaukee, as immediate past president, will be the host; and Dr. W. P. Curran, Antigo, incoming president, will be special guest.

MEDICAL ART SALON

A special annual meeting feature for the third consecutive year—the Medical Art Salon, sponsored by the Woman's Auxiliary to the State Medical Society—promises to be the best yet. Three days—Monday, Tuesday, Wednesday.

SPECIALTY SOCIETY FUNCTIONS

There will be meetings of specialty groups during the annual meeting. Details of these will be announced in the March issue.

OUT-OF-STATE GUEST LECTURERS

DONALD BIRMINGHAM, M.D.
Associate Clinical Professor of Dermatology, University of Cincinnati College of Medicine, Cincinnati, O.

E. T. BOLES, JR., M.D.
Assistant Professor of Surgery, Ohio State University College of Medicine, Columbus, O.

WAYNE H. BORGES, M.D.
Chief, Division of Hematology, Children's Memorial Hospital, Chicago, Ill.

BUELL C. BUCHTEL, M.D.
Head of the Department of Radiology, Ochsner Clinic, New Orleans, La.

PAUL A. CHANDLER, M.D.
Associate Clinical Professor of Ophthalmology, Harvard Medical School, Boston, Mass.

D. W. EASTWOOD, M.D.
Professor of Anesthesiology and Chairman of the Department, University of Virginia School of Medicine, Charlottesville, Va.

EVAN FREDERICKSON, M.D.
Professor of Anesthesiology, University of Kansas School of Medicine, Kansas City, Kan.

SPRAGUE H. GARDINER, M.D.
Professor of Obstetrics and Gynecology, University of Indiana Medical Center, Indianapolis, Ind.

JEROME A. HILGER, M.D.
Clinical Professor of Otology, University of Minnesota Medical School, Minneapolis, Minn.

DAVID YI-YUNG HSIA, M.D.
Professor of Pediatrics, Northwestern University Medical School, and Chief of Division of Biochemistry and Genetics, Children's Memorial Hospital, Chicago

ISADORE LAMPE, M.D.
Professor of Radiology, University of Michigan Medical School, Ann Arbor, Mich.

ARNO MOTULSKY, M.D.
Seattle, Wash.

RICHARD W. STANDER, M.D.
Associate Professor of Obstetrics and Gynecology, University of Indiana Medical Center, Indianapolis, Ind.

BURTRUM C. SCHIELE, M.D.
Professor of Psychiatry, University of Minnesota Medical School, Minneapolis, Minn.

ROBERT T. TIDRICK, M.D.
Professor and Chairman of the Department of Surgery, State University of Iowa College of Medicine, Iowa City, Ia.

HARRY HALL, M.D.
Chairman and Professor of Orthopedic Surgery, University of Minnesota Medical School, Minneapolis, Minn.

Watch for
COMPLETE PROGRAM IN
MARCH ISSUE

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Jack Teasley, and Dr. and Mrs. Milton Gutglass, Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 11–13, 1964

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his wife.

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs. Jack Teasley, Milwaukee, on or before April 1, 1964. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 11, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Wednesday, May 13.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Jack Teasley, 7421 North Crossway Road, Milwaukee, Wis. 53217, BEFORE APRIL 1, 1964.

I plan to submit the following entry or entries for the 1964 MEDICAL ART SALON at the Milwaukee Auditorium, May 11–13.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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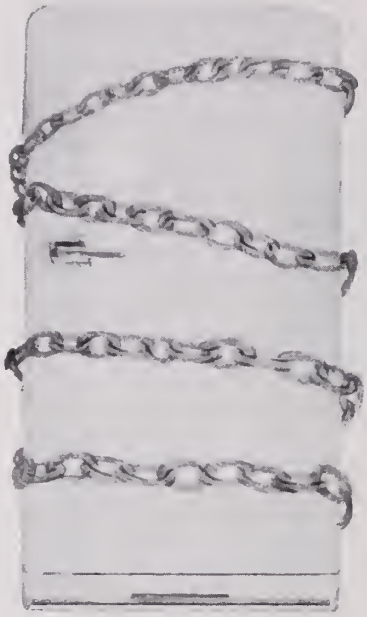
Journal
Established 1903

Annual Subscription ------$6.00
Single Copy ---------- 1.00
Previous Years' --------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.



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News Release

WISCONSIN PHYSICIANS SERVICE ANNOUNCES NEW CONTRACT COVERING DENTAL SERVICES

The first Blue Shield dental care insurance contract to be offered to Wisconsin residents has been approved by the State Insurance Department and will be placed on sale this month by Wisconsin Physicians Service.

The dental policy, called "Prepaid Dental Benefit" Plan, will be available initially to groups only.

"Dental care has always been a significant part of health care costs," said Dr. E. M. Dessloch, Prairie du Chien, chairman of the Society's Commission on Medical Care Plans. "We feel that this new policy will greatly assist the patient in pre-paying the anticipated costs of dental health care."

The plan will cover the dentist's "usual, customary and reasonable" charges for services up to a maximum benefit selected by the group.

"One of the most important features of the policy is that it assures free choice of dentist," Dr. Dessloch added.

Other features of the policy:

- ⋆ It is available to groups of 25 or over.
- ⋆ There are no waiting periods.
- ⋆ It will be offered separately from other WPS health insurance contracts.
- ⋆ Orthodontics and complete dentures are covered on a 50 per cent basis.
- ⋆ Students may be covered to age 23 by endorsement.
- ⋆ It may be purchased on a full payment, or on a deductible basis.

If selected on a deductible basis, the policy is available with a $25, $50, or $100 deductible. Monthly costs will vary according to the one selected; for the $50 deductible, the monthly costs are $2.50 for a single person and $9.50 for a family.

"The new Prepaid Dental Benefit contract will be a further step forward in the pioneering concept of WPS in bringing the broadest possible protection against the costs of health care to the people of Wisconsin," Dr. Dessloch said.

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COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

The Ashland-Bayfield-Iron County Medical Society met January 20. New officers for 1964 were chosen. They are: *Dr. L. W. Moody*, Bayfield, president; *Dr. Robert Sneed*, Ashland, vice-president; *Dr. C. A. Grand*, Ashland, secretary-treasurer; Doctor Grand, delegate; and *Dr. J. M. Jauquet*, Ashland, alternate.

BROWN

The Brown County Medical Society met at the Hotel Northland, Green Bay, on January 9. Dr. Jackson A. Smith, of the Illinois Neuropsychiatric Institute, Medical College, University of Illinois, Chicago, delivered the talk on alcoholism. *Dr. Frank Urban*, Green Bay, secretary of the Society, spoke on the Kerr-Mills program, and the Visiting Nurse Association.

The February 13 meeting of the Society featured Dr. Edward Burk of the pediatrics department, Mayo Clinic, Rochester, Minn., who spoke on "The Acute Abdomen in Children."

CHIPPEWA

The Chippewa County Medical Society met in Chippewa Falls on February 11 at the Hotel Northern. Mr. Glenn Waldschmidt, Rothchild, State Medical Society regional representative, spoke on the King-Anderson bill and led a general and vigorous discussion on the subject after showing the film entitled "Gift of Health." The Society decided to endorse the local cancer unit's poster contest being held in the county on cancer and smoking. Members also decided to cooperate with the education program of the American Cancer Society in helping with radio interviews to be taped for Chippewa radio station WAXX.

DANE

The Dane County Medical Society held its regular meeting, February 11, at the State Medical Society building, Madison. The special guest speaker was Dr. W. C. Bornemeier, vice-speaker, American Medical Association House of Delegates, who spoke on "The Doctor—1970." Special guests at the meeting were University of Wisconsin Medical School students.

New members of the Society are *Dr. Kenneth M. Klatt* and *Dr. John R. Larsen*. Doctor Klatt was born at Macomb, Ill., and received his medical education at the University of Maryland Medical School where he graduated in 1956. He served his internship and currently is in residency at University Hospitals, Madison. Doctor Larsen is a native of Waukesha, and graduated from the University of Wisconsin Medical School in 1959. He completed his internship at St. Luke's Methodist Hospital, Cedar Rapids, Ia., and currently is in residency at University Hospitals, Madison.

Physicians whose names appear in italics are members of the State Medical Society.

DODGE

The new officers for 1964 for the Dodge County Medical Society are: *Dr. N. W. Erickson*, Beaver Dam, president; *Dr. N. H. Schulz*, Horicon, secretary; *Dr. L. W. Schrank*, Waupun, delegate; *Dr. R. E. Urbanek*, Beaver Dam, alternate; and *Dr. G. G. Drescher*, Beaver Dam, censor.

FOND DU LAC

Dr. H. J. Kief, Fond du Lac, was installed as president of the Fond du Lac County Medical Society recently. He succeeds *Dr. C. M. Flanagan*, Fond du Lac. Other officers are: *Dr. Howard Mauthe*, Fond du Lac, vice-president; *Dr. W. G. Kendell*, Fond du Lac, secretary-treasurer; *Dr. D. J. Twohig, Jr.*, Fond du Lac, delegate; and *Dr. W. E. Myers*, Fond du Lac, alternate.

MILWAUKEE

Dr. Lester R. Dragstedt, Gainesville, Fla., spoke to the Medical Society of Milwaukee County at its meeting in January at the Milwaukee Athletic Club. Doctor Dragstedt spoke on "Surgical Treatment of Duodenal Ulcer." He is emeritus professor of surgery at the University of Chicago and research professor of surgery at the University of Florida, and was then serving as the fourth annual Carl Eberbach visiting professor of surgery at the Marquette University School of Medicine.

SAUK

The Sauk County Medical Society met on February 11 in Baraboo. The featured speaker was *Dr. Kenneth Lemmer*, Madison, who gave a talk on "Surgery in Diseases of the Pancreas," it was reported by *Dr. G. W. Zauft*, Prairie du Sac, secretary of the Society.

OUTAGAMIE

The Outagamie County Medical Society met in January in Appleton and heard a talk by Judge Gustave Keller. Judge Keller discussed compulsory work programs and rehabilitation for such law violators as vagrants, alcoholics, and sex offenders.

PORTAGE

The Portage County Medical Society met on February 6 at River Pines Sanitorium. *Dr. A. S. Evans*, Madison, spoke on "Laboratory Tests for Infectious Diseases."

New officers for 1964 are: *Dr. R. H. Slater*, president; *Dr. J. R. Erickson*, vice-president; and *Dr. A. M. Kohn*, secretary-treasurer, all of Stevens Point. The board of censors consists of *Dr. P. N. Sowka*, *Dr. A. G. Dunn*, and *Dr. W. A Gramowski*, all of Stevens Point. The delegate is *Dr. Francis Gehin*, and the alternate is *Dr. A. J. Sowka*, Stevens Point.

RACINE

The Racine County Medical Society cooperated with The Wisconsin Heart Association and presented, on February 1 and 13, talks by two noted heart specialists. On February 1, Dr. Paul Dudley White, dean of American Cardiologists and Eisenhower's medical advisor, spoke on "The Challenge of Heart Disease." On February 13, Dr. Jeremiah Stamler, director of heart disease control, Chicago Board of Health, spoke on "Heart Attacks Can be Prevented." Both meetings were open to the public without charge.

SHEBOYGAN

The Sheboygan County Medical Society has recently activated a committee supplying speakers to the community on the controversial issues involved in health care for the aged. The speakers bureau, comprised of five physicians, has been organized as part of the "Operation Hometown" committee, of which *Dr. R. B. Windsor*, Sheboygan, is chairman. Members of the Society who will serve as speakers are: *Drs. Christopher A. Graf*, *N. Peter Braun*, *Edward E. Houfek*, *John M. Reinemann*, all of Sheboygan, and *Alvin C. Theiler*, Kiel.

WAUSHARA–GREEN LAKE

The Waushara-Green Lake County Medical Society met in Berlin on January 23. *Dr. John H. Esser*, a Milwaukee internist, was guest speaker and discussed recent concepts with regard to etiology of diabetes and some practical applications in treatment. The Society voted to participate with the State Department of Public Health in instituting an oral vaccine program.

WINNEBAGO

The January meeting of the Winnebago County Medical Society featured a talk by *Dr. William F. Kennedy*, Neenah, on "Whip Lash: Fact or Fantasy." The February meeting was held at the Winnebago County Hospital; *Dr. R. H. Bitter*, Oshkosh, was in charge of the program.

CALUMET

Courtesy SHEBOYGAN PRESS

The Calumet County Medical Society has elected its officers for 1964. Seated, from left, are Dr. John A. Knauf, Stockbridge, secretary-treasurer; Dr. Robert Knauf, Chilton, vice-president; and Dr. Francis Larme, New Holstein, president. Standing is Dr. A. C. Engel, New Holstein, convention delegate.

Shown left to right of the Madison Chapter of the Wisconsin Society of Obstetrics and Gynecology meeting are: Dr. C. W. Horswill, Madison; Dr. Nichols Vorys, the guest speaker at the meeting; and Dr. C. Robert Jackson, Madison. Doctor Vorys holds a fireman's hat in recognition of the Visiting Fireman Award presented him by the Chapter.

Wisconsin Society of Obstetrics and Gynecology—Madison Chapter

On Friday, February 7, the Madison Chapter of the Wisconsin Society of Obstetrics and Gynecology met at the State Medical Society building, Madison. It was the first of what is to be considered an annual meeting of the Madison Chapter.

The featured speaker was Dr. Nichols Vorys, assistant professor of obstetrics and gynecology, Ohio State University. Doctor Vorys addressed the group, following a social hour and dinner, on "Use and Abuse of the New Progesterones." He also appeared the next morning at the University of Wisconsin Hospitals for the obstetrical and gynecological grand rounds and talked on "Management of the Anovulatory Patient."

The Chapter presented Doctor Vorys with the first Visiting Fireman Award. The award, an innovation of the Chapter, apparently has its origins in the old saying, "why don't we get a visiting fireman?, etc." The Chapter hopes to make the award an annual one.

There were 35 doctors and residents present for the dinner meeting. Out of town guests came from Kenosha and Janesville, and Dubuque, Ia., and Indiana.

Wisconsin Psychiatric Association

Dr. Edward E. Houfek, Sheboygan, was named president-elect of the Wisconsin Psychiatric Association at the organization's recently concluded annual meeting in Madison. *Dr. Robert E. O'Connor*, Madison, who served as president-elect the past year, will take office as president in May. The president of the Association for the 1963–64 term was *Dr. Keith Keane* of Appleton.

Dr. C. W. Osgood, Milwaukee, was reelected secretary at the meeting and *Dr. Leigh M. Roberts*, Madison, was elected treasurer.

Dr. B. Cullen Burris, Milwaukee, and *Dr. Gilbert B. Tybring*, Madison, were named councilors.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Medical Alumni Association

Dr. Robert C. Hickey, chairman of the surgery department, University of Wisconsin Medical School, Madison, was the main speaker at the meeting of the Medical Alumni Association, University Club, Milwaukee, February 14. Doctor Hickey discussed the surgical program at the University of Wisconsin. Prof. James F. Crow, acting dean of the medical school, was also a speaker at the meeting.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society held its January meeting at the University Club of Milwaukee. Dr. Windsor S. Davies addressed the group on "Complications of Cataract Surgery."

Wisconsin Diabetes Association

Dr. Thomas A. Prier, Milwaukee, was elected president of the Wisconsin Diabetes Association during the organization's annual meeting. The meeting was held in the Association's executive offices at 225 East Michigan Street, Milwaukee. Doctor Prier succeeds *Dr. John H. Esser*, Milwaukee. Others elerted were: *Dr. Addis C. Costello*, Milwaukee, vice-president; and *Dr. William L. Treacy*, Milwaukee, secretary-treasurer.

Wisconsin Diabetes Association officers for 1964 are shown: Past-president Dr. John H. Esser hands the gavel to 1964 president, Dr. Thomas A. Prier. Standing, left, is Dr. Addis C. Costello, vice-president, and Dr. Julius M. Meyer, a director of the Association.

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Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine held its 978th meeting on February 18 at the University Club, Milwaukee. The Arthur W. Rogers Memorial Lecture was presented by Dr. Jack C. Westman, department of psychiatry, University of Michigan. Doctor Westman spoke on "The Patient's Family." The March 17 meeting featured Dr. Maurice H. Seevers, professor and chairman, Department of Pharmacology, University of Michigan, who spoke on narcotics.

American Academy of General Practice—Wisconsin Valley Chapter

Dr. William P. Curran, Antigo, was honored by the Wisconsin Valley Chapter of the American Academy of General Practice at a meeting of the Academy in January. Doctor Curran, a member of the Academy, who practices in Antigo, is the president-elect of the State Medical Society.

During the business meeting, *Dr. Walter L. Lewinnek*, Merrill, was elected president of the Chapter. He succeeds *Dr. Francis Lane*, Merrill. *Dr. Burton K. Smith*, Wausau, was elected vice-president, and *Dr. Charles M. Balliet*, Wausau, secretary-treasurer.

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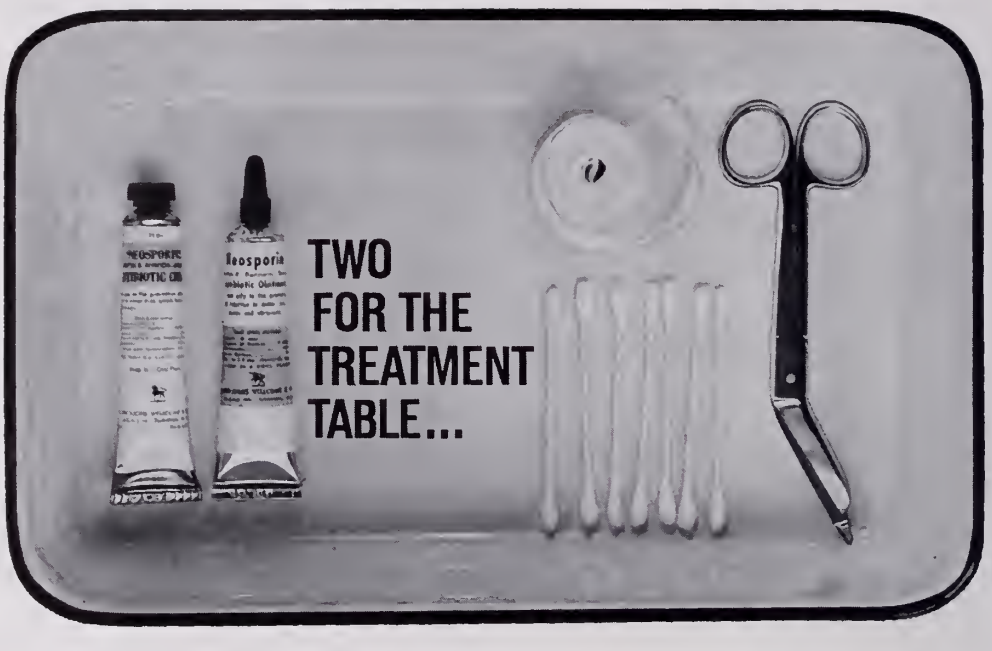

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NEWS OF WISCONSIN PHYSICIANS

Dr. Rosekrans Chief of Staff

Dr. Sarah Rosekrans, who shares a medical and surgical practice in Neillsville with her husband, *Dr. M. C. Rosekrans*, has been elected chief of the medical staff of Neillsville's Memorial Hospital, succeeding *Dr. Kenneth Manz*, Neillsville.

Dr. Daniells Leaves Arcadia

Dr. Albert Daniells, Arcadia, has left there and has joined the staff of the Krohn Clinic at Black River Falls. A native of India and graduate of the University of Nagpur, Doctor Daniells has practiced in Arcadia since 1960.

Dr. Larsen Addresses Kiwanis

Dr. Roy B. Larsen, Wausau, spoke recently to the Wausau Kiwanis Club on the topic of medical care for the aged. He explained both the Kerr-Mills plan and the King-Anderson bill.

Dr. Conley Appointed

Dr. Harold L. Conley, Wisconsin Dells, has been appointed Civil Defense Director of Health and Medical Services for Columbia County. The appointment was made by K. K. Johnson, Columbia County Director of Civil Defense, and confirmed by the Columbia County Civil Defense Commission in December.

Dr. Osicka New Berlin Physician

Dr. Steve R. Osicka, formerly of Amherst, has become a new physician for Berlin. He had a year and a half of medical school in Europe, and attended Northwestern University from 1939 to 1941, receiving his B. S. degree. After Army duty in 1943-1945, he graduated from Marquette University School of Medicine in 1949. His internship was served at Deaconess Hospital, Milwaukee.

Davis Grant Aids Cancer Research

A $62,500 grant from Ralph E. Davis, Houston, Tex., to establish the Euretta Mary Kimball Davis Professorship of Neurosurgery in the University of Wisconsin Medical School, Madison, has been accepted by the Regents. The grant will be used to support basic and clinical research on brain tumors and related conditions. Mr. Davis, a world renowned geologist and petroleum engineer, graduated from the University of Wisconsin in 1906, and has been a long-time benefactor of the University.

Dr. Evenson at Sturgeon Bay and Algoma

Dr. Roland G. Evenson, Sturgeon Bay, is the new radiologist for hospitals at Sturgeon Bay and Algoma. A native of Luxemburg, Doctor Evenson received his M. D. from Marquette University School of Medicine, Milwaukee.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Nauth Honored

Dr. D. F. Nauth, Kiel, was named "Man of the Year" by the Kiel Kiwanis Club. Doctor Nauth has been a practicing physician in the Kiel area for 56 years.

Dr. Crumpton Speaks to Madison Rotary

The Madison Rotary Club recently heard a talk on "Sex and Heart Disease" by *Dr. Charles W. Crumpton*, Madison. Doctor Crumpton is director of the Cardiovascular Research Laboratory at the University of Wisconsin Medical School, Madison.

Dr. Bessire Addresses MARC

Dr. Milton Bessire, Madison, was the speaker at the January meeting of Madison Area Retardation Council, Inc. (MARC).

Dr. Jew Joins Monroe Clinic

Dr. Sik Q. Jew, a neurologist, has joined The Monroe Clinic staff. Doctor Jew received his M. D. degree from the Arkansas School of Medicine, Little Rock, in 1957. He served his internship at Milwaukee County General Hospital, Milwaukee, in 1957 and 1958, and his residencies in neurology at the University of Arkansas Medical Center and the University of Colorado Medical Center. He did postgraduate work as a fellow in neurology at the University of Arkansas Medical Center and was a staff neurologist at the VA Hospital in Hines, Ill., prior to coming to Monroe.

Reports on Mission in S. A.

Dr. Paul Odland, Janesville, reported recently on his medical mission to Colombia, S. A., at the afternoon and evening meetings of the women of the First Lutheran Church, Janesville. Doctor Odland offered to teach orthopedic diagnosis and procedures to South American doctors in four areas. The project of aiding doctors in undeveloped areas was initiated by the late Dr. Tom Dooley.

Dr. Jauquet Speaks at Washburn

Dr. Joseph M. Jauquet, Ashland, spoke recently to the St. Louis Home and School Association, Washburn, on "Growing Up." Doctor Jauquet has practiced medicine in Ashland since 1947.

Dr. Vedder Speaks on HOPE

Dr. J. S. Vedder, Marshfield, gave an illustrated talk on "Project HOPE" at the January meeting of the Jefferson PTA.

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*Donnelly, J. A.M.A. Arch. Environmental Health 6:697, June, 1963

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PHYSICIANS NEWS *continued*

Dr. Schwartz to be Honored

The Wisconsin Chapter of the American Academy of Pediatrics will honor *Dr. Abraham B. Schwartz*, a long-time pediatrician in Milwaukee. Doctor Schwartz was born in 1891 in Macon, Ga., and completed his medical school training at Emory Hospital in 1911. He served his internship at the City Hospital in Atlanta from 1911–1913 and subsequently went to Massachusetts General Hospital where he received an additional year of training from 1913–1914. He took still further residency training at Children's Memorial Hospital, Chicago, from 1915–1916 which was followed by three months of postgraduate work in Vienna.

A. B. Schwartz, M. D.

Doctor Schwartz has been a part-time teacher in the department of pediatrics at Marquette University Medical School for many years and now holds the rank of clinical professor. He became a member of the staff of Marquette University in 1928, and in 1952 was appointed head of the department of pediatrics succeeding Dr. Francis R. Janney and served until 1956. He was certified by the American Board of Pediatrics and has been an emeritus member since 1956. In 1961 Doctor Schwartz withdrew from his practice and is now a member of the Curative Work Shop staff.

The recognition dinner will take place at the University Club, Milwaukee, on May 11 and many of Doctor Schwartz's friends are requested to make reservations with *Harry A. Waisman, M. D.*, Children's Hospital, 1300 University Avenue, Madison.

Dr. Cupery Tells of Kuwait Work

Dr. Dowe Cupery, Markesan, spoke recently to the Ripon Rotarians about his month of work in a Kuwait hospital. Doctor Cupery was called upon to treat diseases comparatively strange to him, such as elephantiasis, tropical diseases, and tapeworm. The visit was sponsored by the Christian Medical Society of Oak Park, Ill., a nondenominational group that helps to supply medical aid to underpriviledged nations.

Dr. Breier Named Staff Head

Dr. H. P. Breier, Montfort, has been elected chief of the medical staff at St. Joseph's Hospital, Dodgeville. *Dr. S. B. Marshall*, Hollandale, was named vice-president, and *Dr. M. T. Erickson*, Highland, secretary.

Edgerton Hospital Medical Staff

Election of officers was held recently at the Memorial Community Hospital, Edgerton. They are: *Dr. H. L. Burdick*, Milton, president; *Dr. J. F. Holmes*, Milton Junction, vice-president; and *Dr. D. A. Cohen*, Edgerton, secretary-treasurer. *Dr. V. S. Falk, Jr.*, Edgerton, still retains the duties of chief of staff.

Dr. Clemence Appointed

Dr. James A. Clemence, Hales Corners, was appointed public health officer for the village of Hales Corners. He succeeds *Dr. R. C. Wolf*, Hales Corners, long-time health officer of Hales Corners, Franklin, and Oak Creek.

Rouse Clinic Open House

An open house was held recently at the new Rouse Clinic, Reedsburg. The clinic staff consists of *Dr. John Rouse*, *Dr. James Tibbitts*, and *Dr. Lancelot Glasson*, all of Reedsburg.

Dr. Tenney Addresses Mental Health Group

Dr. H. Kent Tenney, Madison, addressed members of the Fond du Lac County Mental Health Association at their annual meeting in February. Doctor Tenney, professor emeritus of pediatrics at the University of Wisconsin Medical School, Madison, spoke on "Understanding Children's Problems."

Dr. Rich Joins Madison Practice

Dr. Frederick N. Rich, Madison, has become associated with *Dr. Wayne M. Rounds* and *Dr. Farrell F. Golden*, Madison, in the practice of radiology. Doctor Rich's wife is Dr. Margaret M. Underriner, who was associated with the Dean Clinic, Madison, before her marriage. They are both graduates of the State University of Iowa, Iowa City, and came to Madison from Pacific Palisades, Calif. Doctor Rich practiced general medicine in South Dakota, studied psychiatry in Europe for two years, received his radiology training at Cook County Hospital, Chicago, and practiced radiology at Santa Monica, Calif., for two years.

Dr. Powell Heads Staff

Dr. Richard A. Powell, Kenosha, recently became president of the medical staff at Kenosha Memorial Hospital. *Dr. Frank C. Williams, Jr.*, Kenosha, was named president-elect. *Dr. Stephen Holt*, Kenosha, was named secretary.

Dr. Rusch Speaks to Jaycettes

Dr. Kenneth H. Rusch, Madison, spoke on "First Signs of Mental Illness and What to Do about Them" during the Monroe Jaycette dinner meeting held recently. Doctor Rusch is director of community services of the Division of Mental Hygiene, Wisconsin State Department of Public Welfare, and is also teaching at the University of Wisconsin Medical School, department of psychiatry.

PHYSICIANS NEWS *continued*

Dr. Kiser Speaks to Baraboo Kiwanis

Dr. Joseph C. Kiser, Madison, spoke recently to the Kiwanis Club of Baraboo on diseases of the vascular system.

Dr. Stika Speaks to Women's Club

Dr. Edward A. Stika, Racine, discussed the changing role of the doctor at a recent meeting of the Women's Civic Council of Racine.

Dr. Roesler Speaks to Underwriters

Dr. Marvin J. Roesler, Delavan, addressed the Southern Wisconsin Association of Life Underwriters at a meeting recently. He spoke on medicare.

Dr. Mudge, Dr. Beilman Named to ACP

Dr. William A. Mudge, Jr., Kenosha, and *Dr. Robert L. Beilman*, Madison, recently were selected as associates of the American College of Physicians (ACP). Elected as fellows were *Drs. Frederick P. Krumenacher* and *Julius M. Meyer*, both of Milwaukee.

Dr. Shumate Speaks to Lions

Dr. John K. Shumate, Madison, discussed "Can Tuberculosis Be Forgotten?" recently at the meeting of the Madison Lions Club.

Dr. A. W. Hankwitz Honored

Judge Ronold Drechsler, chairman of the Board of Directors of the Sunday Morning Breakfast Club, recently presented *Dr. Arthur W. Hankwitz*, Milwaukee, with a certificate of Recognition of Loyalty to our Community and our Country and outstanding Civic Service, at the new Central Y.M.C.A., West Wisconsin Avenue, Milwaukee. A full house of friends and well wishers witnessed the presentation.

Dr. Sowka Appointed

Dr. Albin Sowka, Stevens Point, has become infirmary medical director of the Portage County Infirmary. He succeeds *Dr. R. H. Rifleman*, Stevens Point.

Dr. Connolly Practices in Merrill

Dr. James Connolly has become associated with *Dr. F. C. Lane*, Merrill, Doctor Connolly, a native of northern Ireland, was graduated from the Royal College of Physicians and Surgeons, Dublin, in 1950.

Medical Center Open House

An open house was held in January for the new medical center just completed in LaFarge. *Dr. Conrad Lee*, LaFarge, has moved into one of the suites. The project was financed by loans and gifts.

NIH Health Grants

Several National Institutes of Health (NIH) grants have been awarded recently to University of Wisconsin doctors. Recipients of general research grants are Drs. Robert I. DeMars, *D. Murray Angevine*, John W. Anderegg, *Ben M. Peckham*, and Gessner H. Echols. Also receiving grants are Dr. Masayasu Nomura, allergy; Dr. James M. Price, arthritis; John W. Porter, Ph.D., arthritis; and Harland W. Mossman, Ph.D., child health.

Dr. Uhrich Officer of Year

Dr. Gerard I. Uhrich, La Crosse, was appointed "officer of the year" by the La Crosse Chapter of the Reserve Officers Association of the U. S. Army Organized Reserve. The appointment was made at the end of 1963 for the year 1963.

Swiss Professor at U-W

Dr. Nikolaus Mani, internationally known Swiss Scholar, has been appointed visiting professor in history of medicine at the University of Wisconsin Medical School, Madison, for the second semester. An authority on the history of liver research, Doctor Mani studied medicine at the Universities of Zurich and Geneva.

Dr. Senty Attends Course

Dr. R. M. Senty, Sheboygan, attended the postgraduate course on "What's New in Internal Medicine 1963" held in January by Northwestern University at Passavent Memorial Hospital, Chicago.

Dr. Larson to Menasha

Dr. Owen E. Larson, Clintonville, has moved to Neenah and has become associated with *Dr. Paul E. Wainscott*, Menasha. Doctor Larson had practiced in Clintonville since 1952.

Dr. Herner on Vacation

Dr. William L. Herner, retired Milwaukee physician, has been on an extended vacation in Honolulu, Hawaii.

Dr. Mulvaney Joins Marshfield

Dr. John J. Mulvaney, formerly of Traverse City, Mich., has joined the Marshfield Clinic, Marshfield. Doctor Mulvaney received his M. D. from Loyola University, Chicago, in 1944. For a year prior to graduation, he served in the Army Medical Corps, and after interning at Mercy Hospital, Oshkosh, he again served in the medical corps for two years. Then he joined the staff at Winnebago State Hospital for five years, after which he opened offices at Clintonville and Wausau. In 1961, Doctor Mulvaney gave up his practice and took up graduate work in psychiatry at Traverse City, Mich., State Hospital, where he has been until accepting his present position.

Marshfield Clinic Officers

Officers and members of the executive committee were reelected at the annual meeting of the Marshfield Clinic held in January. They are: *Dr. G. Stanley Custer*, president, and *Dr. R. F. Lewis, Jr.*, vice-president. Renamed to the executive committee were *Drs. N. J. Helland, James S. Vedder, Ben R. Lawton, J. L. Ousley* and *William H. Heywood.* Doctor Custer reviewed the accomplishments of 1963, noting that the year marked the greatest period of growth in the history of the Marshfield Clinic. Ten specialists were added to the staff as were 26 paramedical aides. At the end of the year, the clinic had a total of 55 specialists and 203 full and part-time employees.

Dr. Collentine Addresses PTA

Dr. George Collentine, Milwaukee, chief surgeon and a member of the "burn team" at St. Mary's Burn Center, Milwaukee, recently showed slides and spoke of the progress in methods of treatment in serious burn cases to the Randall School P.T.A., Waukesha. His primary purpose was to warn each parent of hidden dangers in the home. He said that 90 per cent of the emergencies brought to the Burn Center could have been prevented and that a large percentage of these are children.

Jaycees Cite Dr. Johnson

Dr. J. Martin Johnson, Ripon physician for 40 years, was the recipient of the Ripon Junior Chamber of Commerce Distinguished Service Award for 1963. Doctor Johnson was cited for his accomplishments in founding and developing the Ripon Cerebral Palsy and Rehabilitation Center, Inc. He received his M. D. at Northwestern University in 1921 and in 1923 started general practice in Ripon.

Medical Missionary Shows Film

Dr. J. Birney Dibble, Eau Claire, presented a series of four film narrations in February at the Grace Lutheran Church and Lake Street Methodist Church, Eau Claire. Doctor Dibble recently returned from Africa where he has been serving for the previous year as a medical missionary in the area of Tanganyika, East Africa.

Annual Meeting of Marshfield Foundation

Photo courtesy MARSHFIELD NEWS–HERALD

Dr. Nicholas C. Hightower, Jr. (center), director of the section on clinical research at Scott and White Clinic, Temple, Tex., was the principal speaker at the annual meeting of the Marshfield Clinic Foundation for Medical Research and Education held in Marshfield. With him are Dr. G. Stanley Custer (left), who introduced the speaker, and Dr. Stephan Epstein, president of the Foundation, both of Marshfield.

The annual meeting of the Marshfield Clinic Foundation for Medical Research and Education, Marshfield, was held in January at the Marshfield Clinic. Those attending heard reports on the 1963 activities of the Foundation, and heard Dr. Nicholas C. Hightower, Jr., Temple, Tex., discuss the role of a research program in the group practice of medicine. The officers, all reelected, are: *Dr. Stephan Epstein*, president; *Dr. Dean Emanuel*, vice-president; Frederick J. Wenzel, director of laboratories, secretary; and Floyd R. Detert, clinic administrator, treasurer. Named to succeed themselves to three-year terms on the board were Mr. Detert, *Dr. Norman J. Helland, Dr. Robert M. Heywood*, and Mr. Wenzel. Implementing the decision to expand the board of directors from 12 to 15 members, the group elected *Dr. Jack Lees* for a one-year term; *Dr. George River*, two years; and *Dr. Richard D. Sautter*, three years.

Dr. Allen to Europe

Dr. James C. Allen, a native of Brodhead, and a 1959 graduate of the University of Marquette School of Medicine, is going to Europe for six months, and will study at the Institute of Ophthalmology, University of London. He will return in the fall. Doctor Allen has just completed his residency in ophthalmology at the University of Wisconsin Medical School, Madison.

Dr. Price Speaks to Cancer Society

Dr. James M. Price, Madison, of the University of Wisconsin Cancer Research Hospital, was the main speaker in January for the Madison meeting of the American Cancer Society Crusade.

Dr. Dibble Joins Dean Clinic

Dr. Phillip A. Dibble, a native of Baraboo, and graduate of the University of Wisconsin Medical School in 1955, has joined the staff of the Dean Clinic, Madison, in the practice of otolaryngology. Doctor Dibble interned at Tripler General Hospital, Honolulu, Hawaii; received specialty training at Stanford University; completed three years residency at Walter Reed General Hospital, and has served as consultant to the U. S. Army at Frankfürt, Germany. He was certified by the American Board of Otolaryngology in June, 1963.

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Dr. Correll is President of Staff

Dr. Howard L. Correll, Milwaukee specialist in internal medicine, has been elected president of the medical staff of Milwaukee County General Hospital. He succeeds *Dr. Leo R. Weinshel,* Milwaukee. *Dr. Ross C. Kory,* chief of research medicine at Veterans Administration Hospital, Wood, is vice-president, and *Dr. Benjamin G. Narodick,* a thoracic surgeon, Milwaukee, is secretary-treasurer.

Dr. Fetherston Retires

Dr. John P. Fetherston, Milwaukee, a fireman's son, has retired as chief physician of the Milwaukee Fire Department. Doctor Fetherston, who describes fire fighting as his "first love," estimates that he has been called to 200 fires since 1950. He was graduated from Marquette University School of Medicine in 1925 and then entered private practice.

Dr. Nachazel Joins Eye Group

Dr. Delbert P. Nachazel, Jr., is now associated with *Drs. Bolger, Bolger & McCormick* in Milwaukee and Waukesha. He is specializing in ophthalmology with a special interest in retinal detachment surgery and retinal diseases. Doctor Nachazel received his M. D. degree from Marquette University School of Medicine in 1958. He interned at St. Joseph's Hospital, Milwaukee, and then completed an eye residency at the Illinois Eye and Ear Infirmary, after which he received a year's training in retinal detachment surgery and retinal diseases at the Retinal Foundation in Boston, Mass.

Dr. Kabler Speaks

Dr. J. D. Kabler, assistant professor of medicine, University of Wisconsin, Madison, spoke on "The Emotional Aspects of Illness" at the doctor-clergy meeting at Madison General Hospital, held in January.

Dr. Rice Heads Staff Again

Dr. Thomas J. Rice, Marshfield, was reelected chief of staff at the annual medical staff meeting of St. Joseph's Hospital, Marshfield. Also reelected was the vice-chief of staff, *Dr. James W. Manier,* Marshfield. *Dr. Nelson Moffat,* Marshfield, was named secretary to succeed *Dr. Charles Bowerman,* Marshfield.

Racine Citizen of Year

Dr. Arthur B. Grant, Racine, was picked as 1963 Racine Citizen of the Year by the State Street Business and Professional Men's Association who

honored him at a dinner in January. Doctor Grant was chosen on the basis of his work as campaign chairman in the 1963 Racine United Fund Drive.

Dr. Simmons Talks to Lions

Dr. Warren K. Simmons, Rhinelander, spoke recently to the Rhinelander Lions Club. In his talk, he emphasized the fact that about 85 per cent of the persons who suffer heart attacks recover to lead useful, pleasant lives, and the outlook for future treatment of heart conditions is "most hopeful."

Dr. Van Riper Appointed at Geigy

Dr. Hart E. Van Riper, New York City, was appointed vice-president for medical affairs of Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, it was announced this winter. In this position Doctor Van Riper will direct the increasing contacts with government health authorities and medical organizations that are required now of the pharmaceutical industry. Since 1956, Doctor Van Riper has served as medical director of Geigy Pharmaceuticals.

From 1946 to 1956, Doctor Van Riper served as medical director of the National Foundation for Infantile Paralysis. During that time, the Foundation's activities expanded significantly, culminating in 1956 with development of Salk polio vaccine.

A graduate of the University of Pennsylvania Medical School, Doctor Van Riper for several years was assistant director of maternal and child health in the U. S. Department of Labor Division of Health Service. Later he became medical director of the Jackson Memorial Hospital, Miami, Fla.

He practiced as a pediatrician in Madison from 1933 to 1941. He is a member of the Dane County Medical Society, State Medical Society of Wisconsin, American Medical Association, American Board of Pediatrics and the American Academy of Pediatrics.

Correction

Inadvertent omissions of names of State Medical Society members in the Membership Roster which appeared in the January 1964 Blue Book issue are:

Alfred N. E. Merton, M.D., Milwaukee
Thomas J. Kozina, M.D., Milwaukee
Our apologies!

Be sure to see the full page feature on

A UNIQUE CHRISTMAS CARD

which appears on page 170 of the scientific section of this issue of the *Wisconsin Medical Journal*

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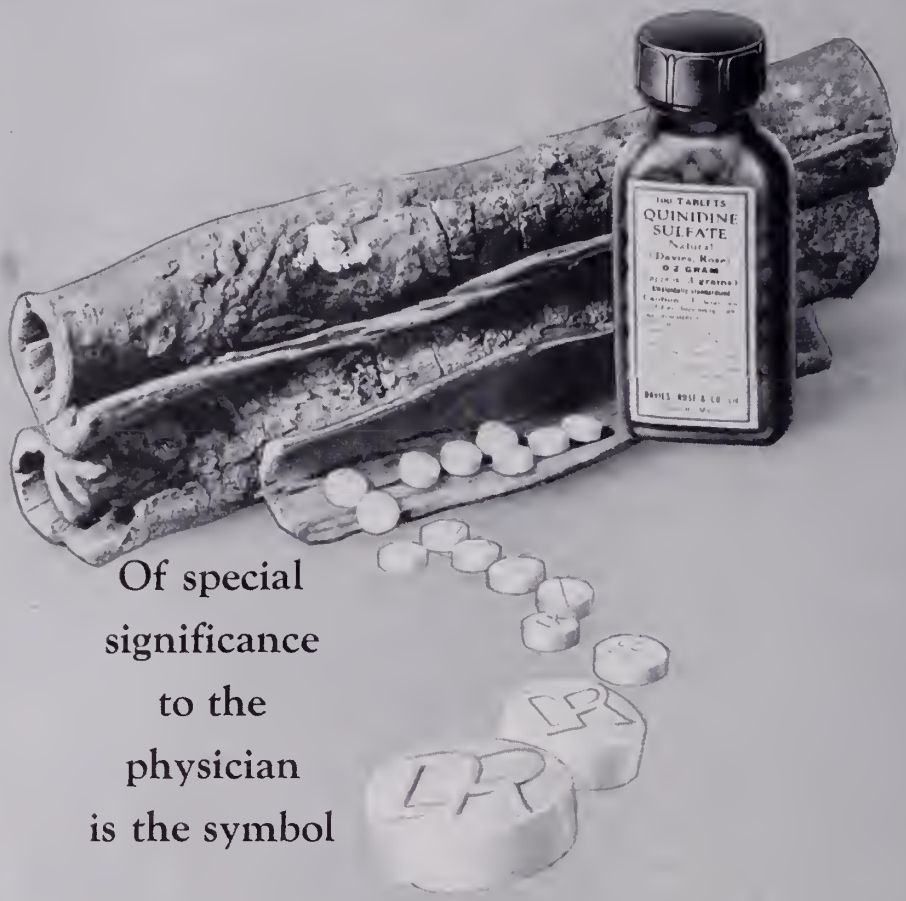

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JANUARY 15, 1964

NEW MEMBERS

Jon Arvin Anderson, 808 Third Street, Wausau.
Gordon L. Backer, 502 Third Street, Wausau.
Donald V. Blink, 480 East Grand Avenue, Wisconsin Rapids.
G. H. Brister, Medical Arts Building, Wausau.
Merle L. Brose, N89 W16800 Appleton Avenue, Menomonee Falls.
Alan B. Cameron, 650 South Central Avenue, Marshfield.
Quentin C. Case, 2925 Rapids Drive, Racine.
Eleanor Delfs, 8700 West Wisconsin Avenue, Milwaukee.
Joseph C. Devine, 105 Sheboygan Street, Fond du Lac.
William V. Dovenbarger, Marshfield Clinic, Marshfield.
Frank J. Erdlitz, P. O. Box 27, Ontario.
Alan A. Ehrhardt, Route 1, Oakfield.
Fred W. Fletcher, 650 South Central Avenue, Marshfield.
Robert J. Gagan, 144 West Madison Street, Waterloo.
Piero G. Gasparri, 3003 South 45th Street, Milwaukee.
Walter J. Gerstle, 6225 Seventh Avenue, Apt. 302, Kenosha.
Malcolm E. Gillespie, 40 West Newton, Rice Lake.
David E. Goodnough, 1300 University Avenue, Madison.
Erdal Y. Gursoy, Winnebago State Hospital, Winnebago.
Richard F. Hearn, P. O. Box 42, West Bend.
Robert J. Hlavac, 3338 South Whitnall Avenue, Apt. 8, Milwaukee 7.
Dennis R. Howard, 2712 Marshall Court, Madison 5.
Donald M. Kinkel, 650 South Central Avenue, Marshfield.
George J. Krismer, 425 Jefferson Street, Burlington.
James A. Kunkel, 650 South Central Avenue, Marshfield.
Peter Lameka, 24 West Marshall, Rice Lake.
Rudolfo S. Lastrilla, Germantown State Bank Building, Germantown.
Hendrik Leering, Reedsville Clinic, Reedsville.
Arthur S. Ludwig, Jr., Osceola Clinic, Osceola.
William J. McAweeney, 30 South Henry Street, Madison.
Paul S. Messinger, 8700 West Wisconsin Avenue, Milwaukee.
George F. Meisinger, Route 3, Box 233 C, Fond du Lac.
Angelo Milano, St. Michael's Hospital, Stevens Point.
Joanna R. Miller, 2525 Taylor Avenue, Racine.
Thomas O. Miller, 808 Third Street, Wausau.
Thomas F. Nikolai, 650 South Central Avenue, Marshfield.
Joseph C. Pellicer, 2020 Madison Street, New Holstein.
John Peters, Gavin Clinic, Fond du Lac.
James C. Pinney, Hilbert.
Robert W. Pointer, 1720 North 8th Street, Sheboygan.
Gerald E. Porter, 650 South Central Avenue, Marshfield.
William E. Prickman, 1313 Fish Hatchery Road, Madison.
Robert F. Purtell, Jr., 758 North 27th Street, Milwaukee.
John E. Reinert, 1836 South Avenue, La Crosse.
Cesar J. Remus, V. A. Center, Wood.
Robert N. Richards, 650 South Central Avenue, Marshfield.
Philip P. Ruetz, V. A. Center, Wood.
Wayne L. McFadden, West Lafayette, O., to 926 Milwaukee Avenue, South Milwaukee.
George S. Metcalf, Janesville, to 1024 Seventh Avenue, Lewiston, Ida.
Lee E. Miller, Milwaukee, to 8410 West Cleveland Avenue, West Allis.
Sydney M. Miller, 30 Cambridge Road, Madison 4.
John T. Murphy, P. O. Box 456, Sturgeon Bay.
Edward P. Onderak, Milwaukee, to 1447 North Harrison Street, Saginaw, Mich.
L. B. Perssion, 9033 Watertown Plank Road, Milwaukee.
Louis J. Ptacek, Madison, to R.F.D. #1, Waunakee.
Garry A. Quinn, Milwaukee, to Sheboygan Clinic, Sheboygan.
Martin A. Rammer, Jr., New York, to Brooks AFB, San Antonio, Tex.
Leland K. Reeck, Madison, to 2635 North Rosemont, Tucson, Ariz.
Mac C. Roller, Whiteland, Ind., to 68 Price Road, R.R. #2, Plainfield, Ind.
Douglas A. Sallis, Boyd, to 204½ North Broadway, Stanley.
Gloria E. Sarto, 5402 Regent Street, Madison.
Edmund William Schacht, 114 Seventh Street, Racine.
Benjamin H. Schlomovitz, 2165 North Hi Mount Boulevard, Milwaukee.
L. T. Servic, 400 West Silver Spring, Milwaukee.
John O. Simenstad, 731 Parkway Drive, St. Paul.
Hubert W. Simonsen, Janesville, to 2100 East Jarvis, Shorewood 11.
B. K. Smith, 400 Strollers Lane, Wausau.
Claude A. Taylor, Amarillo, Tex., to Department of Anesthesiology, Emory University, Atlanta 22, Ga.
John W. R. Thoma, 400 West Silver Spring, Milwaukee.
Virgil R. Vanstane, Madison, to General Delivery, Whitesville, W. Va.
David E. Vig, 125 West Jefferson, Viroqua.
DeVerne W. Vig, 125 West Jefferson, Viroqua.
Edward N. Vig, 125 West Jefferson, Viroqua.
Annette C. Washburne, 219 North Midvale Boulevard, Madison.
M. A. Warpinsky, 101½ North Washington, Green Bay.

REMOVED FROM MEMBERSHIP

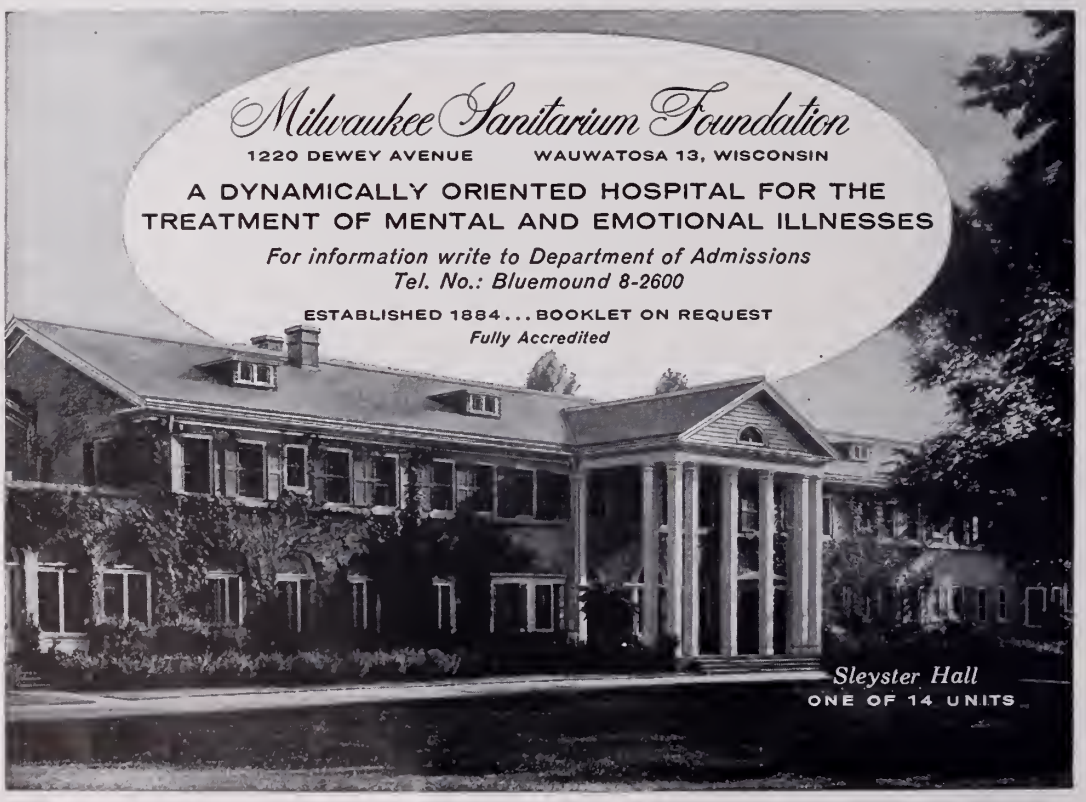
D. W. Bailey, Milwaukee County, resigned.
Henry Brown, Dane County, transferred to Massachusetts.
Richard D. Carr, Dane County, transferred to Ohio.
Glenn A. Childers, Milwaukee County, transferred to Florida.
William J. Deschler, Milwaukee County, resigned.
Joseph N. Dockery, Racine County, transferred to California.
Theodore T. Draelos, Milwaukee County, transferred to New Mexico.
Stafford W. Gedge, Wood County, transferred to Minnesota.
James R. Hanson, Dane County, transferred to Washington.
Donald J. Garland, Lafayette County, transferred to Arizona.

SOCIETY RECORDS *continued*

Anthony M. Kowalski, Milwaukee County, transferred to Kansas.
Harold B. Miner, Milwaukee County, requested by County Medical Society secretary.
Marilyn J. O'Brien, La Crosse County, transferred to Illinois.
Charles E. Roger , Milwaukee County, transferred to New York.
Louis M. Rosenheimer, Milwaukee County, resigned.
George C. Shonat, Chippewa County, transferred to Illinois.
Thomas E. Simonsen, Milwaukee County, resigned.
W. M. Stoll, Brown County, transferred to Nevada.
Leif O. Torkelson, Dane County, transferred to Kentucky.
Donald F. Watzke, Dane County, resigned.
Paul J. Whitaker, Milwaukee County, transferred to Pennsylvania.

DEATHS

Eugene E. Flemming, Marathon County, September 20, 1963.
John O. Muehlhauser, Door-Kewaunee County, October 30, 1963.
Leonard S. Shemanski, Green Lake-Waushara County, November 9, 1963.
Charles O. Lindberg, nonmember, November 11, 1963.
Harold G. Pudleiner, Door-Kewaunee County, November 23, 1963.
John W. O'Neill, nonmember, November 30, 1963.
Benjamin H. Dike, nonmember, December 10, 1963.
Harry H. Prudowsky, Milwaukee County, December 14, 1963.
Emory P. Paine, Milwaukee County, December 20, 1963.
James P. Pauly, La Crosse County, December 25, 1963.
Harry M. Guilford, Dane County, December 26, 1963.
Hans W. Hefke, Milwaukee County, December 29, 1963.
Robert C. Thompson, Barron-Washburn-Sawyer-Burnett County, January 3, 1964.
Eugene F. Pischke, Sauk County, January 7, 1964.
Nonito M. Sablay, Lakeland Hospital, Elkhorn.
Morris H. Sable, 2500 West Lincoln, Milwaukee.
John R. Sadd, 5301 Regent Street, Madison.
Hugo Schlagintweit, Arcadia.
William F. Schorr, 650 South Central Avenue, Marshfield.
William J. Schulte, 8222 Red Arrow Court, Wauwatosa.
Francesco Sciarrone, 313 North Fremont Street, Stevens Point.
Richard Siedenburg, 232 South Main, Jefferson.
William H. Sigalove, 92 East Division, Fond du Lac.
James A. Sisk, 477 East Tenth Street, Fond du Lac.
Harold E. Smith, 240 Allen Street, Clinton.
John F. Stageman, Grantsburg Clinic, Grantsburg.
Kenneth L. Strebe, 134 North Main Street, Oconto Falls.
Neil Swissman, 8828 North Port Washington Road, Milwaukee.
Ralph E. Tomkiewicz, 524 Main Street, Racine.



June D. Unger, V. A. Hospital, Wood.
Louis F. Warrick, Jr., 30 South Henry Street, Madison 3.
Wayne F. White, Holy Family Hospital, Manitowoc.
Roy J. Wiarda, Kenosha Hospital, Kenosha.
E. Bruce Wohlwend, 207 South University Avenue, Beaver Dam.
Irving V. Wright, 8700 West Wisconsin Avenue, Milwaukee.

REINSTATED

C. W. Docter, Plum City.
Arno R. Langjahr, 9086 North Meadowlark Lane, Milwaukee.

CHANGES OF ADDRESS

George W. Arndt, Sr., 413 Beaulieu Road, Neenah.
V. A. Baylon, Janesville, to 1526 Grand Avenue, Racine.
Robert Bein, 3803 Alden Court, Racine.
Andrew Boyd, Jr., 400 West Silver Spring, Milwaukee.
Arthur Chandler, Jr., 1308–22nd Street, Monroe.
Harry Chinchinian, Milwaukee, to Box 629, Lewiston, Ida.
Ralph A. Clark, Milwaukee, to 910 North Elm Grove Road, Elm Grove.
John J. Czajka, 10691 West Parnell Avenue, Hales Corners.
James B. Dibble, Tanganyika, East Africa, to 405 South Farwell Street, Eau Claire.
Ettore Di Miceli, Jr., 12700 Green Meadow Place, Elm Grove.
H. H. Fechtner, 400 Strollers Lane, Wausau.
Timothy T. Flaherty, Ripon, to 5733 Bittersweet Place, Madison.
Carl A. Gehring, 1702 Michigan Boulevard, Racine.
Calvin J. Gillespie, 1025 West North Avenue, Milwaukee.
Rex E. Graber, Chippewa Falls, to 718 West Clairemont Avenue, Eau Claire.
Lester E. Haushalter, 2515 Wauwatosa Avenue, Milwaukee.
Murray Herman, 407 North Main Street, Thiensville.
Donald D. Hillan, Fond du Lac, to 505 South Grand Street, Waukesha.
A. W. Hoessel, 400 Strollers Lane, Wausau.
L. F. Jermain, 6745 West Wells Street, Milwaukee.
Elmer C. Kocovsky, Box 7232, Wauwatosa.
Frederick K. Kolb, Anna M. Reiss Home, Sheboygan.
C. H. Kratchovil, New York, to 6571 ARL, Holloman AFB, New Mexico.
R. B. Larsen, 400 Strollers Lane, Wausau.
Edward S. Levy, 407 North Main Street, Thiensville.
William J. Little, 834 Main Street, Racine.
Benjamin W. Louthan, 2828 North 122nd Street, Milwaukee.
E. P. Ludwig, 400 Strollers Lane, Wausau.
Joseph T. Majewski, 10425 West North Avenue, Milwaukee.
C. R. Marlewski, Milwaukee, to Route 1, Stone Lake.
Jacob H. Martens, Oregon, to 1715 Adams Street, Madison.

SMS ANNUAL MEETING
May 11–12–13, 1964
Milwaukee Auditorium and Hotel Schroeder

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Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
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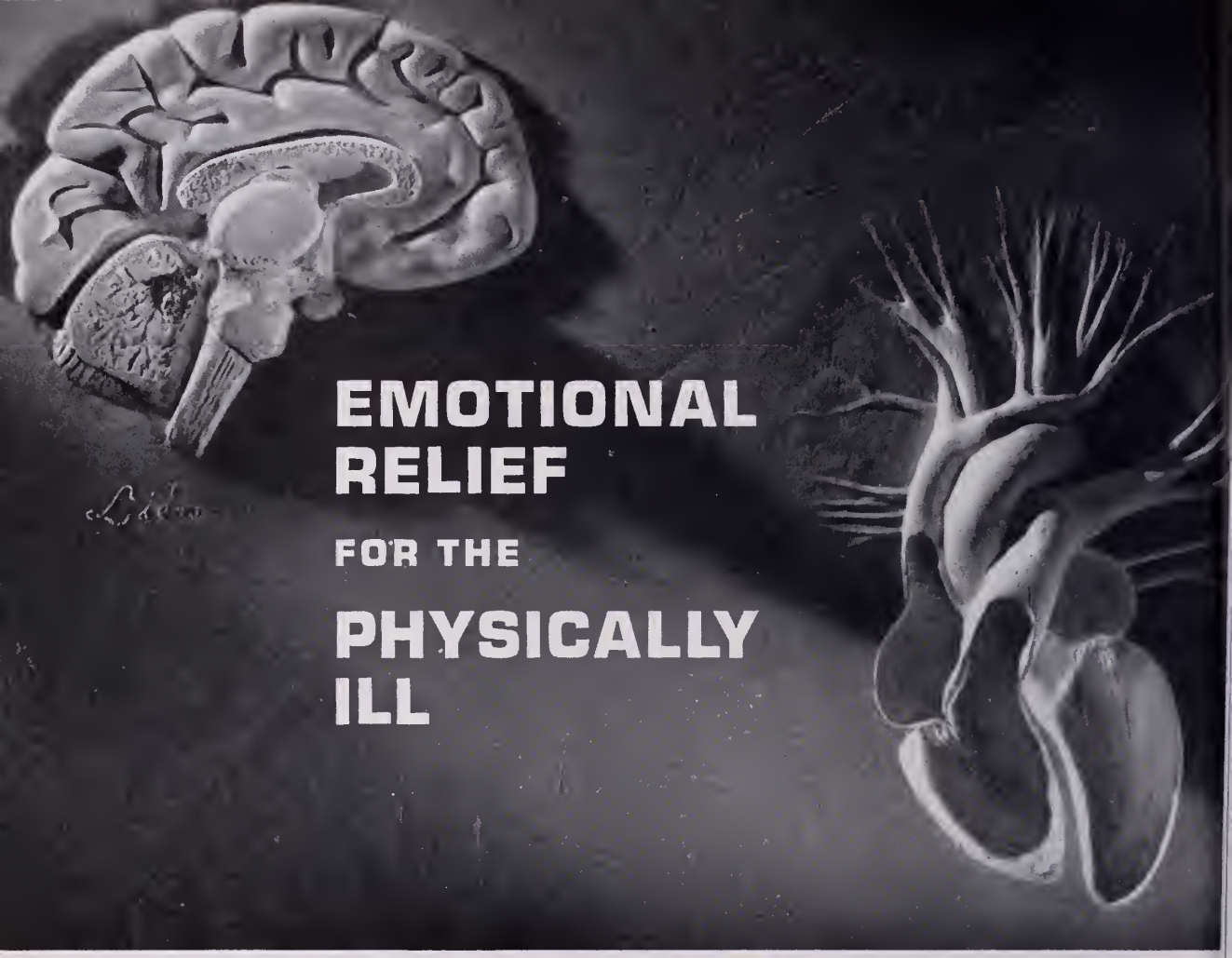

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1964 **Wisconsin**

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

Apr. 16–17: Institute for Hospital Administrators, Trustees, and Chiefs of Staff, Milwaukee.

Apr. 17–18: Health Fads & Fallacies Conference, State Medical Society of Wisconsin, Port Edwards.

Apr. 22–24: Wisconsin Public Health Association and Middle States Branch of the American Public Health Association, joint meeting, Schroeder Hotel, Milwaukee.

Apr. 27–29: Annual session, Wisconsin State Dental Society, Milwaukee.

May 7: University of Wisconsin Medical School Field Day, Madison.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

1964 **Out-of-State**

Apr. 3–5: American Society of Internal Medicine, 8th annual meeting, Atlantic City, N. J., Claridge Hotel.

Apr. 6–10: American College of Physicians, Annual Meeting, Convention Hall, Atlantic City, N. J.

Apr. 13–16: American Industrial Health Conference, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.

Apr. 27–29: Tri-State Hospital Assembly, 34th Annual Meeting, Palmer House, Chicago.

May 1–2: AMA Congress on Environmental Health Problems, Chicago.

May 5–15: Postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," University of Cincinnati College of Medicine and Christ Hospital, Cincinnati.

May 9–14: American Proctologic Society and Section of Proctology of the Royal Society of Medicine, Philadelphia, Pa.

May 9: American Rhinologic Society, Samuel Iglauer Memorial Lectures, University of Cincinnati College of Medicine, Cincinnati, O.

May 11–14: 35th Annual Scientific Meeting of the Aerospace Medical Association, Americana Hotel, Miami Beach, Fla.

May 22: Symposium on Clinical Aspects of Acute Leukemia, sponsored jointly by American Cancer Society and the National Cancer Institute, New York Hilton, New York City.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 1–5: American College of Physicians postgraduate course No. 17, "Recent Advances in Clinical Nutrition," Lemuel Shattuck Hospital, Boston, Mass.

June 1–5: Annual Meeting of the Medical Library Association, St. Francis Hotel, San Francisco, Calif.

June 8–12: American College of Physicians postgraduate course No. 18, "Recent Progress in Endocrinology," University of Washington School of Medicine, Seattle.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

June 21–25: 113th annual convention of the American Medical Association, San Francisco, Calif.

June 22–25: Catholic Hospital Association convention, New York City.

Aug. 3–7: University of Colorado School of Medicine, 7th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 24–27: American Hospital Association, Chicago.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 21–25: Animal Care Panel, 15th annual meeting, Hilton Hotel, New York City.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 26–29: National Safety Congress, Chicago.

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

Catholic Hospital Association Convention

The Catholic Hospital Association's Convention will be held June 22–25, at the New York Hilton Hotel, New York City. The dates coincide with the New York World's Fair, and the convention-goer will be able to attend the convention and the fair. More information on the program of the meeting may be obtained from: Catholic Hospital Association, 1438 South Grand Boulevard, Box 1, St. Louis, Mo. 63104.

American College of Physicians

The American College of Physicians Postgraduate Course No. 14, "Current Concepts in the Physiology of Respiration, Circulation and Electrolytes," will be held April 2–4 in Atlantic City, N. J. It is cosponsored by the American Physiological Society, and will be given just prior to the Annual Session of the American College of Physicians. The three-day session will be devoted to summarizing physiologic information for the practicing physician. It will be concerned with providing an authoritative and precise summary of the current status of knowledge of physiologic processes in the respiratory system, the circulatory system and the electrolyte metabolism.

American Society of Internal Medicine

The American Society of Internal Medicine will hold its eighth annual meeting in Atlantic City, N. J., April 3–5, at the Claridge Hotel. The title of the meeting is "External Influences on Internal Medicine." There is no registration fee for members or guests. More information may be obtained by Writing: American Society of Internal Medicine, 3410 Geary Boulevard, San Francisco, Calif. 94118.

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MEDICAL MEETINGS *continued*

American Proctologic Society

The American Proctologic Society and the Section of Proctology of the Royal Society of Medicine will meet May 9–14 at the Bellevue Stratford Hotel, Philadelphia, Pa. Copies of the preliminary program may be obtained by writing Dr. Harry E. Bacon, 255 South 17th Street, Philadelphia, Pa. 19103.

Tri-State Hospital Assembly

The thirty-fourth annual meeting of the Tri-State Hospital Assembly will be held Apr. 27–29, at the Palmer House, Chicago. It is sponsored by the Illinois, Indiana, Michigan, and Wisconsin State Hospital Associations. "Better Education for Better Patient Care" is the theme of the meeting which will feature over 300 educational exhibits, nearly 60 educational conferences, an increased number of general assemblies, and the introduction of multidisciplinary sessions. Copies of the registration forms may be obtained from the headquarters office: Tri-State Hospital Assembly, 400 North Michigan Avenue, Chicago, Ill. 60611.

Postgraduate Course in Pediatrics

The University of Colorado School of Medicine, Denver, Colo., presents the seventh annual postgraduate course in pediatrics on August 3–7, at the Stanley Hotel, Estes Park, Colo. The tuition fee for the five-day course, which offers a great variety of subjects and seminars, is $75.00, including a nonrefundable registration fee of $10.00. Registration is now open and may be applied for by writing the office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

American Industrial Health Conference

By means of closed-circuit color television, prominent medical authorities will demonstrate diagnostic techniques, examination procedures and methods for the prevention of occupational disease and illness to those attending the American Industrial Health Conference at the Pittsburgh-Hilton Hotel, April 13–16. This national conference, which encompasses the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses, is expected to attract more than 2,000 persons, including many physicians whose practice is only partly industrial, as well as those who are engaged as full-time industrial physicians, industrial nurses, public health officials, military physicians, management representatives and others who have an interest in the health of the working population.

Joint Meeting in Milwaukee

The Hospital Administrator-Chief of Medical Staff-President of Governing Board Conference will be held on Thursday, April 16, at the Coach House

Motor Inn, West Wisconsin Avenue at 19th Street, Milwaukee. The meeting will open with registration at 8:00 a.m. The general session will be held from 9:00 to 10:30 a.m. and will be conducted by Mr. John M. Danielson, executive vice-president; Mr. John L. Lewis, president of the board of trustees; and Dr. Leonard F. Jourdonais, chairman, Department of Medicine, and professor of medicine, Northwestern University Medical School, all of the Evanston (Illinois) Hospital. Each will speak on the responsibilities, as they see them, of the hospital administrator, the physician, and the board, in providing for a high level of quality patient care.

Following the general session, there will be a coffee break from 10:30 to 10:45 a.m. and then the participants will be divided into small discussion groups. Lunch will be from 12:00 n. until 1:00 p.m., following which participants will go back into discussion groups. Coffee break will be from 2:30 until 2:45, then at 3:30 p.m. all participants will convene into a general session for a conference summary which will be done by Mr. Danielson with adjournment scheduled for 4:00 p.m.

The conference will be sponsored by the State Medical Society, Marquette University School of Medicine, and the Wisconsin Hospital Association. It will be restricted to joint attendance of the hospital administrator, the chief of the medical staff, or his designate, and the president of the board, or his designate. Registrations will not be accepted from any hospital unless all three persons plan to attend.

AMA Annual Convention

The AMA Council on Postgraduate Programs announced that the scientific program for the 113th Annual Convention in San Francisco, June 21–25, is virtually complete, and that an attendance of between 15,000 and 16,000 physicians is anticipated.

When the AMA held its last convention in San Francisco in June 1958, the total physician registration was 13,997.

Dr. J. Arnold Bargen, Temple, Tex., chairman of the Council on Postgraduate Programs, which plans the scientific programs for the Association's two conventions, the annual and clinical, said that the San Francisco program will be most comprehensive, including lectures, scientific exhibits, preview showings of medical films, and color television.

Dr. John Hickam, Indianapolis, chairman of the program planning committee of the Council, said that the following general scientific meetings have already been coordinated by section secretaries: Differential Diagnosis of the Liver and Pancreas; Hyperbaric Oxygen Phenomena; Computers in Medicine; Autoimmune Mechanisms and Disease, Cardiovascular Opacification, and Tumors of the Endocrine Function. In addition, a special half-day program on various aspects of heart disease will be offered by the American College of Cardiology and the American Heart Association.

The popular and interesting Research Forum program, under the chairmanship of Dr. Edwin H.

Ellison, Milwaukee, will be offered again at the San Francisco Meeting. Sixty papers, based on new and original work being done in the nation's medical schools, will be delivered by young, outstanding researchers. In contrast to previous forums, one or two major areas of research, possibly organ transplantation and hyperbaric oxygen in the treatment of disease, will be covered in a symposium presentation.

A general scientific meeting program that has already elicited considerable interest is the half-day session on Hyperbaric Oxygen Phenomena—the science of administering oxygen at super atmospheric pressure.

All of the 21 sections, representing various specialties in medicine, are formulating interesting and educational programs for the San Francisco Convention. Subjects include toxicants and insecticides, chronic ulcerative colitis, psychiatry in general practice, gynecology for the general practitioner, ecology to closed environments (submarines and space craft), basic courses in hand surgery and common foot problems, prosthetics, differential diagnosis of the liver and pancreas, management of lower extremity amputees in the light of recent research, procedures for the treatment of anorectal diseases, and contamination and infection of the bladder and kidney.

Complete forms for hotel reservations, as well as for advance convention registration, appear periodically in all AMA publications. The entire scientific program and all essential information for attendance will be published in the Convention Issue of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION on May 9.

WPHA and Middle States APHA

Two nationally known keynote speakers, a general session on a unique behavioral study, another general session on a variety of pertinent topics, and eight special interest sessions are set for the annual Wisconsin Public Health Association (WPHA) meeting on April 22, 23, and 24, in Milwaukee at the Schroeder Hotel. This year's meeting will be held jointly with the annual meeting of the Middle States Branch of the American Public Health Association (APHA).

James Crow, Ph.D., professor of medical genetics and acting dean of the University of Wisconsin Medical School, will open the session, speaking on "Major Crisis in Population." Doctor Crow will be followed by Ivan Nestingen, a former Madison mayor and now under-secretary of the Department of Health, Education and Welfare. Mr. Nestingen will speak on the trends, problems and issues of the federal government's role in support of state and local health services.

The second day's general session will cover the subject "Population Shift and Its Effect on Health Services." A number of speakers will cover various aspects of the population shift, including: Environmental Health, Rural Health Services, Community Health Services, and Changing Trends in Processing and Distribution of Food.

The final day's general session will feature Dr. H. F. Harlow, director of the University of Wisconsin Primate Laboratory. Doctor Harlow has received international recognition for his studies of the behavioral patterns of primates, and his address will be on "The Effect of Early Experience on Heterosexual and Maternal Behavior."

Scheduled between the general sessions are eight special interest sessions. On Wednesday, April 22, such topics as Maternal and Child Health, Mentally Ill Outside Institutions, Use of Television by Health Agencies, and How Communities Work Together will be covered. On Thursday, April 23, the topics will be Agency Roles in Controversial Issues, Training, Nursing Homes, and Statistical Services and Epidemiology.

Those interested in the meeting and the Wisconsin Public Health Association are invited to contact Paul Schuster, State Board of Health District Office, 250 Mormon Coulee Road, La Crosse, Wisconsin 54602.

Medical Library Association

The 1963 annual meeting of the Medical Library Association will be held in San Francisco, Calif., June 1–5 at the St. Francis Hotel. More information regarding program and exhibits may be obtained from the Medical Library Association, 919 North Michigan Ave., Chicago, Ill. 60611.

Conference on Engineering in Medicine and Biology

The 17th annual conference on Engineering in Medicine and Biology will be held in Cleveland at the Sheraton-Cleveland Hotel, Nov. 16–18, 1964.

The meeting, cosponsored by the Institute of Electrical and Electronics Engineers and the Instrument Society of America will feature symposia on topics in selected areas of Biomedical Engineering. In addition, there will be several sessions of contributed papers as well as a number of informal discussion groups. These activities will be complimented by commercial and scientific exhibits indicative of the level of progress achieved in this rapidly maturing interdisciplinary field.

The Conference will be attended by approximately 1,200 individuals from the scientific and technical community including engineers, physical scientists, physicians, and other life scientists.

For further information, contact Dr. David G. Fleming, Conference Chairman, Case Institute of Technology, Cleveland 44106.

Wisconsin State Dental Society

Members of the State Medical Society of Wisconsin have been invited by Dr. H. L. Kieren, president of the Wisconsin State Dental Society, to attend the

scientific program of the Society's 94th annual session at the Milwaukee Auditorium, Milwaukee, April 27–29. The theme of this year's program will be "Denta-Vision: Complete Dentistry—For All." Guest badges allowing admittance to the meeting may be obtained in the registration area at the Kilbourn Avenue entrance. The only identification necessary is the current State Medical Society membership card.

Animal Care Panel

The fifteenth annual meeting of the Animal Care Panel will be held at the Hilton Hotel, New York City on September 21–25. Further information concerning the meeting may be had by writing Mr. Joseph J. Garvey, 4 East Clinton Street, Joliet, Ill. 60434.

Southern Medical Association, Ophthalmology

The Section of Ophthalmology of the Southern Medical Association announces that the next annual meeting will be held in Memphis, Tenn., Nov. 16–19. Papers are now being accepted up to May 15, for presentation at the meeting. For further information, communicate with the Secretary, Dr. George S. Ellis, 812 Maison Blanche Building, New Orleans, La.

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Artificial Cardiac Resuscitation

The Heart Disease Control Program of the Division of Chronic Diseases is sponsoring an instructor's course in closed chest cardiac resuscitation to be given at Johns Hopkins Hospital later this year. The course as presently scheduled will take one full day and will be presented in two parts: a morning session consisting of a film and slide presentation as well as demonstration and supervised practice on the "Resusci-Anne" mannequin; an afternoon session consisting of demonstrations in drug and electrical management of artificially induced cardiac arrhythmias in dogs.

The aim of the course is to produce a group of highly trained instructors who will be able to conduct similar sessions under their local circumstances for physicians, nurses, or rescue personnel. To implement this, each participant will receive a set of teaching slides and pamphlets for his own use. A film and mannequin will be made available to him on loan upon request. The expense of travel to the course and the course itself will be covered by contractual agreement between the Heart Disease Control Program and Johns Hopkins Hospital; thus, the only investments of the participants will be those of time and interest.

If there are any physicians who might be interested in such a course and are in a position to apply the information thus gained, or if further information is desired contact: Dr. William L. Ross, Regional Program Director, Chronic Diseases, Department of Health, Education, and Welfare, Regional Office, 433 West Van Buren St., Room 712, Chicago, Ill. 60607.

ACS Chicago Committee on Trauma

The Eighth Postgraduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons (ACS) will be held April 22–25, at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

Sir Reginald Watson-Jones of London, England, an eminent orthopedic surgeon and outstanding lecturer, will be the honored visiting guest lecturer and will speak on Pitfalls in Radiographic Examination; Repair of Fractures—Safe Conservation or Dangerous Operation; Operative Treatment of Fractures; Ununited Fractures—How to Achieve Certain Success; Dislocations and Recurrent Dislocations of the Shoulder; How Do I Treat Fractures of the Femur; Unusual and Difficult Problems in the Treatment of Fractures and Dislocations; and Rehabilitation After Bone and Joint Injury.

The registration fee will be $75.00. Each registrant will be a guest of the Chicago Regional Committee on Trauma for one luncheon and for the cocktail party on Thursday evening, April 23, at the Drake Hotel, Chicago.

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Wisconsin Anti-Tuberculosis Association

"Greater Cincinnati's Tuberculosis Eradication Project" will be explained to Wisconsin residents at the 1964 annual meeting of the Wisconsin Anti-Tuberculosis Association. The explanation will be presented by Dr. Kenneth I. E. Macleod, commissioner of the Cincinnati Health Department, at the start of the afternoon session on April 3.

The WATA annual meeting is scheduled at the Coach House Motor Inn, in Milwaukee, April 2 and 3.

A native of Scotland, Doctor Macleod was graduated from Edinburgh University in 1935. He was awarded a master's degree in public health from the University of Michigan in 1950, after which he did public health work in Massachusetts for 10 years, resigning to assume his present post in early 1961. He was elected a fellow of the American Public Health Association in 1952.

"New Goals for Old Lungs" is the title of the WATA keynote address to be given by Dr. Katharine R. Boucot, professor and chairman of the department of preventive medicine, Woman's Medical College of Pennsylvania, Philadelphia. Distinguished in her chosen field, chest diseases, Doctor Boucot will outline concepts on tuberculosis eradication.

The meeting will open on April 2 with a Christmas Seal campaign workshop for local associations, with Betty Leman, associate director of the National Tuberculosis Association's Christmas Seal Division, as guest speaker.

Also on April 3, a symposium of WATA staff members will explain the why and how of "Operation KO-TB." Participating in this part of the program will be WATA executive secretary, C. W. Kammeier; medical director, Dr. R. P. Jahn; case finding director, Mrs. Alma Abel, R.N.; research and development director, Richard Merz; and field organizer, William Salvadori. The panel will be joined by representatives of Winnebago County who participated in that county's "KO-TB" program.

The annual WATA membership meeting is scheduled for April 3 and will be followed by a luncheon at which Dr. C. W. L. Jeanes, executive secretary of the Canadian Tuberculosis Association, will speak.

AMA Congress on Environmental Health

The American Medical Association will sponsor the AMA Congress on Environmental Health Problems May 1–2 in Chicago at the Sheraton-Chicago Hotel.

The theme of the Congress is "Can Some Diseases Be 'Engineered' Out of the Environment?". The Congress will center on four major areas of environment that have been related to health—air pollution, water pollution, pesticides, and radiation.

The Congress will aim its program content directly toward the physician in practice, centering on the relation of environmental health problems to medical practice and role of the physician in evaluation and prevention.

American Rhinologic Society

The Samuel Iglauer Memorial Lectures, commemorating the twentieth anniversary of the death of the esteemed Cincinnati savant, pioneer in rhinology and professor of otorhinolaryngology, will be presented at the University of Cincinnati College of Medicine, Saturday, May 9, at 4 p.m.

They will include: "Tribute and Appreciation," by Dr. Raymond L. Hilsinger, assistant professor of otorhinolaryngology, University of Cincinnati College of Medicine; "Modern Olfactometry," by Dr. H. A. E. van Dishoeck, professor of otorhinolaryngology, State University of Leiden, The Netherlands; and "Graphic Rhino-Sphygmo-Manometry," by Dr. Maurice H. Cottle, professor of otorhinolaryngology, University of Chicago Medical School.

The memorial program will be presented at the midpoint of the sixth international postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid" to be given May 5–15 through the joint efforts of the University of Cincinnati College of Medicine, Christ Hospital of Cincinnati, and the American Rhinologic Society.

Among the guest lecturers for the course will be one Wisconsin physician—Dr. Irwin Gaynon of Milwaukee.

American College of Physicians

The American College of Physicians (ACP) will hold its 45th annual session in Atlantic City, N. J., April 6–10.

The five days of meetings will include rounds of scientific education aimed at keeping internists abreast of medical development. The College's annual convocation, featuring the induction of 400 physicians to Fellowship in the College and the conferring of three Masterships and 10 Corresponding Fellowships to physicians of other countries, will be held Thursday evening, April 9, in Convention Hall.

Another highlight of the annual meeting will be the presentation of ACP annual awards to men of distinction in various fields of medical science.

The scientific portions of the meeting will cover topics ranging from gastrointestinal disorders and the diagnosis and treatment of heart diseases to reports on family allergies, infections, lung, liver and kidney diseases, virus problems and conditions involving metabolic function and the endocrine glands.

Even one of medicine's oldest symptoms, the common fever, will be discussed during a morning seminar aimed at exploring its causes and regulation.

Highlights of the scientific program include color television presentations on a closed circuit, sessions on basic medical sciences and clinical investigation, panel discussions and hospital clinic sessions.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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LETTERS

NEEDS FOR CANCER RESEARCH

To WMJ:

As Chairman of the Board of Directors of the American Cancer Society, Wisconsin Division, I am writing to make known to you a request of the Directors that the Editorial Board of the WISCONSIN MEDICAL JOURNAL consider publication of the enclosed article.

We have observed that many physicians are queried by the general public as to the need for voluntarily contributed funds in the support of cancer research when today many millions of dollars are being supplied for this purpose by the Federal government. We feel Doctor Heidelberger has explained this need quite well. Furthermore, we feel that much interesting information regarding some phases of cancer research are also provided through his article.

RALPH C. FRANK, M.D.
Eau Claire, Wisconsin

(EDITOR'S NOTE: *The following remarks were made by Charles Heidelberger, Ph.D., American Cancer Society Professor of Oncology, McArdle Memorial Laboratory, University of Wisconsin, Madison, Wisconsin, before the American Cancer Society's Executive Directors Conference in Louisville, Kentucky, June 6, 1963.)*

■ THESE ARE exciting times in research! The fusion of biology, biochemistry, physical chemistry, and genetics into the field that is now known as molecular biology has led to a depth of understanding of life processes undreamed of as little as five years ago. The brilliant elucidation of the double-stranded structure of DNA by Watson and Crick less than a decade ago has opened a Pandora's box of such proportions that it seems that a solution to our understanding of life itself is almost within reach. The new dogma of the trinity of DNA, RNA, and protein, as promulgated by its high priests, now explains in detailed fashion how hereditary genetic information is transcribed and gives rise to the enzyme proteins that comprise the machinery of the cell. The control mechanisms that enable cells to respond with exquisite sensitivity to their environment are beginning to be understood. The structure and function of viruses—macromolecules on the borderline of life—are now yielding their secrets to investigators. From these viruses nucleic acids have been prepared that are, by themselves, capable of entering cells, subverting them to their own purposes, and producing disease. Vistas are now opening up of new experimental approaches to an understanding of the very complicated problems of cellular differentiation. And, perhaps most exciting, the genetic code whereby the genetic information is read out into specific amino acids, has been cracked, and within a very few years will be known in all its details. It is esthetically very satisfying to note that throughout the hosts of microorganisms, and plant and animal cells (including tumors) that have been examined, this code appears to be universal.

Since the cancer problem is clearly a problem in molecular biology, the promise and excitement of this new knowledge is being carried over into cancer research. Indeed, cancer research has made many of the primary contributions to this almost dizzying progress.

How did this fortunate situation come about? I believe that this rather fantastic progress arose as a combination of circumstances. After World War II the peaceful byproducts of the atomic energy program, radioactive isotopes, became available to scientists and provided new tools of unheard-of versatility and sensitivity. Coupled with this development was the tremendous increase in the financial resources devoted to medical and biological research. This availability of financial support to suitably qualified investigators stimulated more people to enter careers in research, and has enabled young investigators to carry out independent and original research, and at a much earlier age than was hitherto possible. This, in turn, has led to a renascence of enthusiasm and intellectual inquiry in the field of biology.

Now, what of *cancer research*, itself, in the light of the revolution in biology? In the frenzied pace of modern research we are holding our own and making much progress. It is now clear that there are no fundamental differences in the DNA, RNA, and proteins of cancer cells as compared to normal ones, and even the genetic code itself appears to be the same. We must reorient our attempts to find differences between cancer cells and normal ones in a more subtle and sophisticated way, and in keeping with the new knowledge. It is now beginning to look as though cancer cells and normal cells differ, in that the former may have defective control

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing.

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mechanisms and are not able to adapt as readily as the latter to changes in the environment.

What are some of the most important and active areas in cancer research today?

1. Viruses have been implicated in cancer causation. One of the exciting developments of the past decade has been the increased number of viruses that have been shown to produce tumors in experimental animals. Progress has also been made in understanding the nature of virus-cell interactions. However, I believe it is a widespread misconception that viruses cause most human cancers. Thus far it has not been proved that any form of human cancer is caused by a virus, although such proof might be very difficult to obtain. It seems likely, *in my opinion*, that a few human cancers will turn out to be caused by viruses, but not the majority.

2. Chemical carcinogenesis, which a few years ago, in the first flush of enthusiasm for virus-induced tumors, was considered obsolete, is certainly a major cause of cancer in man. Our increasingly complex civilization exposes us to a host of carcinogenic chemicals in cigarette tars, industrial smogs, automobile exhausts, rubber tires, burnt foods, and food additives, to mention a few. Increasing vigilance is needed to guard against these hazards, and the field of cancer epidemiology is burgeoning with efforts to correlate and understand environmental and geographic factors which may lead to cancer. In many laboratories, including my own, slow but steady progress is being made in efforts to understand at the level of molecular biology mechanisms whereby these chemicals can give rise to cancer.

3. The biology of cancer cells has received a new impetus with the recent observations of consistent chromosomal abnormalities in some human leukemias. Other important studies involve investigations of the nature and control of the cell cycle in human cancer cells. These have been obtained from patients, long dead, such as Helen Lang, whose He La cervical cancer cells, are immortalized by growth in bottles in many laboratories throughout the world. New techniques of electron microscopy have made possible great strides in visualizing the ultrastructure of normal and malignant cells.

4. Biochemical comparisons of the differences between normal liver and a variety of rat liver tumors of varying growth rates have revealed subtle differences in control mechanisms, and may pave the way for a closer understanding of the essence of malignancy and hopefully for a more rational chemotherapy.

5. Extensive research in the realm of chemotherapy has led to the development of a few drugs that are useful in the palliation and prolongation of life of patients with advanced cancer. Very recent clinical investigations have led to new and more effective use of existing drugs, such as administration by continuous intraarterial infusion, and

combination with radiotherapy, with results that are often dramatic.

6. The immunology of cancer is a very difficult and tantalizing field. Although there is at present very little in the way of concrete fact to go on, particularly in humans, there are a few hints that this field may become more firmly established. These hold out the possibility of the very elusive goal of prevention through immunization.

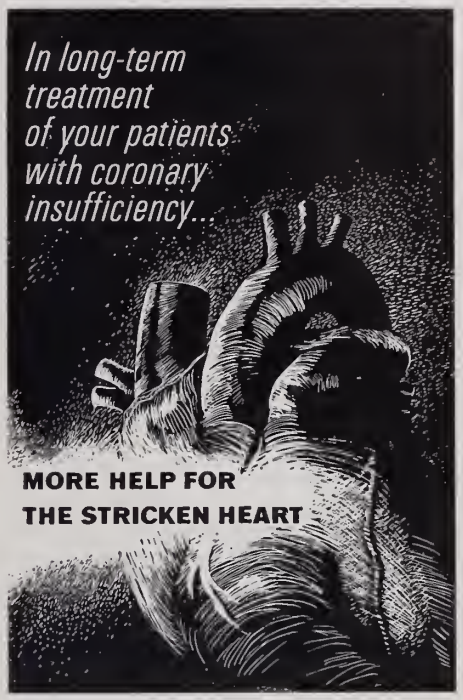
It is my firm and unshakable conviction that some day cancer will be controlled. At the same time I believe that it is irresponsible and dangerous nonsense to mislead the public into believing that a cure is "just around the corner." The public will not easily forget promises that are not kept. I believe that the scientists, their institutions, and the science writers can communicate with the public fruitfully, if they do so factually and with restraint. The Science Writers' Seminars, sponsored by the American Cancer Society, have produced real progress towards this end.

Cancer is a hideous disease. I firmly believe that those of us who are primarily engaged in the laboratory, ivory-tower approach to mouse cancer should periodically go on clinical rounds, into operating rooms and radiotherapy clinics. It is only in this way that we can keep continually aware of the nature of our real adversary—human cancer. My students make these distressing visits, and so do I.

It is hardly necessary to reaffirm that cancer research is a very expensive undertaking. Last year 34% of the total expenditures of the American Cancer Society was devoted to research; this amounted to 13 million dollars. During the fiscal year ending June 30, 1962, the National Cancer Institute spent approximately 59 million dollars for comparable purposes. Is this too much money? I emphatically believe that it is not!

In this period of enormous governmental expenditures for cancer research I believe that it is fair to ask (and I am sure that this question has been asked many times by potential contributors), is there any excuse for a voluntary agency such as the American Cancer Society to continue to exist?

Before I attempt to answer this question, and it will be in the affirmative, let me state that I am far from impartial in this matter. The greatest professional honor that has been accorded to me was the award in 1960 to the University of Wisconsin of a lifetime Research Professorship for me by the American Cancer Society. This has been a source of great satisfaction and pride to me and has had real practical value as well. To me, it would be unthinkable for a single agency to be the sole source of financial support for cancer research. I have no doubt that all my scientific colleagues and friends are similarly horrified by the possibility of such a monopoly. If the Amercan Cancer Society and other nongovernmental agencies should cease to exist, the National Institutes of Health would come close to constituting such a monopoly. It is



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certainly true that in recent years they have provided the major share of cancer research support, and their cooperation and good relations with the American Cancer Society have been heartwarming. Nevertheless, at the present time the N.I.H. have come under the scrutiny of congressional groups that see research more in terms of fiscal accountability than in terms of scientific knowledge and human gains. As a result, the N.I.H. have tightened up many of their regulations relative to research grants and in consequence some of the flexibility in funding has been lost.

Flexibility is a very important word. It is imperative for creative and productive research. Flexibility in research is a unique characteristic of ACS granting policies, and in my opinion the Society's principal benefit to the research community.

Let me illustrate this flexibility with two examples as they applied to me. It became clear to me that a biological technique called *organ culture* would be of great benefit to my research on carcinogenic hydrocarbons. This technique was originated at the Strangeways Laboratory in Cambridge, England and has reached its highest state of development there. Consequently, I wished to spend six months learning and working in that laboratory. I had been at the University of Wisconsin for thirteen years and had not taken any leave to work elsewhere. Under ordinary conditions I would have had to take leave without pay and try to get a Fellowship to support this trip. However, the added flexibility of my American Cancer Society Professorship permitted my salary to continue uninterrupted during my stay in England and made it unnecessary for me to apply elsewhere. Now, having learned this technique of organ culture I returned to my laboratory and wished to start applying it. However, a considerable amount of rather expensive equipment was necessary in order to begin. If I had had to apply for a regular research grant it would have taken almost a year to obtain the funds. The *flexibility* provided by the American Cancer Society made it possible for me to start almost immediately. This came about because the University of Wisconsin is fortunate in having an Institutional Research Grant from the American Cancer Society. One of the main purposes of this grant is to provide interim funds so that new projects can be started; "long-shots" can be tested, and preliminary data can be obtained so that conventional research grants can subsequently be applied for. This flexibility, this willingness to support some gambles in research, makes the American Cancer Society an enormous and unique force in supporting creativity in cancer research. For this reason alone, it should continue to be supported generously by the public.

I would like to suggest that the American Cancer Society could achieve even greater flexibility and assume a new dimension in the support of cancer research if it would provide funds for building and remodeling of research facilities. Some of the most important research in the country is being done in pitifully inadequate and hopelessly overcrowded facilities. Substantial funds are urgently needed to improve these conditions.

You and I should be very proud of the American Cancer Society, and this pride should be passed along to the general public. Do you and they know that the American Cancer Society pioneered the use of impartial committees of competent scientists to review the merits of research proposals? This technique has been uniformly adopted by practically all granting agencies, including the N.I.H. Do you and they know that the American Cancer Society pioneered the idea of the Lifetime Professorships, such as I am privileged to hold? The N.I.H. now offer comparable Career Awards. Do you and they know that the American Cancer Society pioneered the idea of *program*, as contrasted with *project* grants? Program grants are now awarded by the N.I.H. Do you and they know that the American Cancer Society pioneered the Institutional Grant? This, also, has been recently adopted by the N.I.H. I am confident that in the future the American Cancer Society will continue to innovate and lead the way in funding for research.

The volunteers and the staff of the Society come into contact most with the public. When you are asked by them what justification there is for the need for research funds from private donations, tell them all you can. Tell them that these are the most exciting times cancer research has ever known. Tell them that real and exciting progress is being made that needs freedom, flexibility, and adequate support. Tell them of the dangers of financial monopoly. Tell them that research workers and facilities and organizations all over the world are uniting and pooling their knowledge and programs to conquer this disease. Tell them that the conquest of cancer is inevitable. But tell them that this final triumph will not come quickly, easily, or cheaply, and will require great patience and understanding not only on the part of the investigators, but on the part of the public as well—the public that is asked to dig deeply into its pocket every year. Tell them—no, ask them—to have faith in the competence and dedication of the scientists and doctors who are battling this disease, who daily face disappointment and frustration, but who make the progress that is undeniably being made by coming to grips on a sustained basis with the maddeningly perplexing problems of cancer.

SMOOTH OPERATION HELPFUL

To SMS:

I would like to express my personal appreciation and that of the Wisconsin Psychiatric Association for the use of the State Medical Society facilities on the occasion of the recent state meeting of the Wisconsin Psychiatric Association on January 31 and February 1, 1964.

I would also like to express appreciation to (staff members) for cooperation in setting up arrangements and flexibly meeting our needs as they developed over the course of the two days. Each portion of the program went well and the smoothness of the proceedings was in substantial measure due to (staff members) cooperation.

LEIGH M. ROBERTS, M.D.
Program Chairman
Madison, Wisconsin

A GRATEFUL WIDOW

To SMS:

I wish to thank you for your many kindnesses since the death of my husband, Dr. David M. Daley. The information was invaluable and not furnished by any other source. I also received the marked copy of the Journal. It is good to know the State Medical Society can retain such a human touch in spite of its size. My sincere appreciation.

CATHERINE M. DALEY
La Crosse, Wisconsin

TRICHLORETHYLENE (TRILENE)

To SMS (DIV. ON MATERNAL AND CHILD WELFARE)

Your communication regarding the use of Trilene by nurses has been duly noted. We have the communication from Doctor William Kreul but would like to have some other references regarding the dangers of nurse administration of Trilene under supervision of the obstetrician. Have there been any bad experiences in this state reported by our Maternal Mortality Committee or from the Infant, Maternal and Child Welfare Committee? Also, could you give me references as to accidents with this type of administration?

A WISCONSIN PHYSICIAN

To A WISCONSIN PHYSICIAN:

Your letter . . . to the Division on Maternal and Child Welfare has been referred to me for answer. . . .

I am enclosing the circular that accompanies the drug, trichlorethylene. The pamphlet states that trichlorethylene is an analgesic agent (1) (3) (5), not an anesthetic (3) (4), and is not recommended for anesthesia nor the induction of anesthesia (2). "Under no circumstances should the inhaler be held over the patient's face by anyone other than the patient himself (7)." Also, note that medical supervision of self-administration is recommended (6).

The basis for these remarks by the manufacturer of the drug is in accord with the known toxicities (animal experimentation and clinical experience) as reviewed by the Federal Government under whose permit the manufacturer operates. The medicolegal implications of the use of this drug contrary to these directions and cautions should be apparent.

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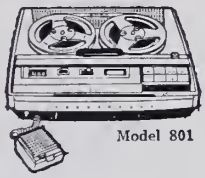

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LETTERS *continued*

An excellent review article on trichlorethylene containing 115 references appears in *Anesthesiology* 21:67, 1960.

When anesthesia (unconsciousness) is established with trichlorethylene, a high incidence of cardiac irregularities (Barnes, C. G., and Ives, J.: Electrocardiographic changes during Trilene anaesthesia, *Proc. Roy. Soc. Med.* 37:528, 1944) that lead to cardiac arrest occur (Norris, W., and Stuart, P.: Cardiac arrest during trichlorethylene anaesthesia, *Brit. M. J.* 1:860, 1957; Bernstine, M. L.: Cardiac arrest occurring under trichlorethylene analgesia, report of a case with recovery, *A.M.A. Arch. Surg.* 68:262, 1954) and a tachypnea develops. The latter may double or triple the normal rate. At double the rate Dundee (*B. J. Anaesth.* 25:3, 1953) found a 25 per cent drop in arterial oxygen saturation.

There have been two deaths in the State (Wisconsin) as reviewed by the Maternal Mortality Study Committee, one in 1956 and one in 1957. The Committee would like to ward off future deaths that will come if the drug is used improperly. Recently, the fact that the drug is being used incorrectly was brought to the attention of the Committee. The *Wisconsin Medical Journal* article (Kreul, William: Trilene, trichlorethylene, Trimar analgesia in obstetrics, April 1963) and the letter to hospital staffs followed.

Trusting that this communication is helpful to you and assuring you that further correspondence with (the Division) or myself will be welcome.

WILLIAM KREUL, M.D.
Racine, Wisconsin

NEW POSITION FOR SK&F FIELD MEN

To SMS:

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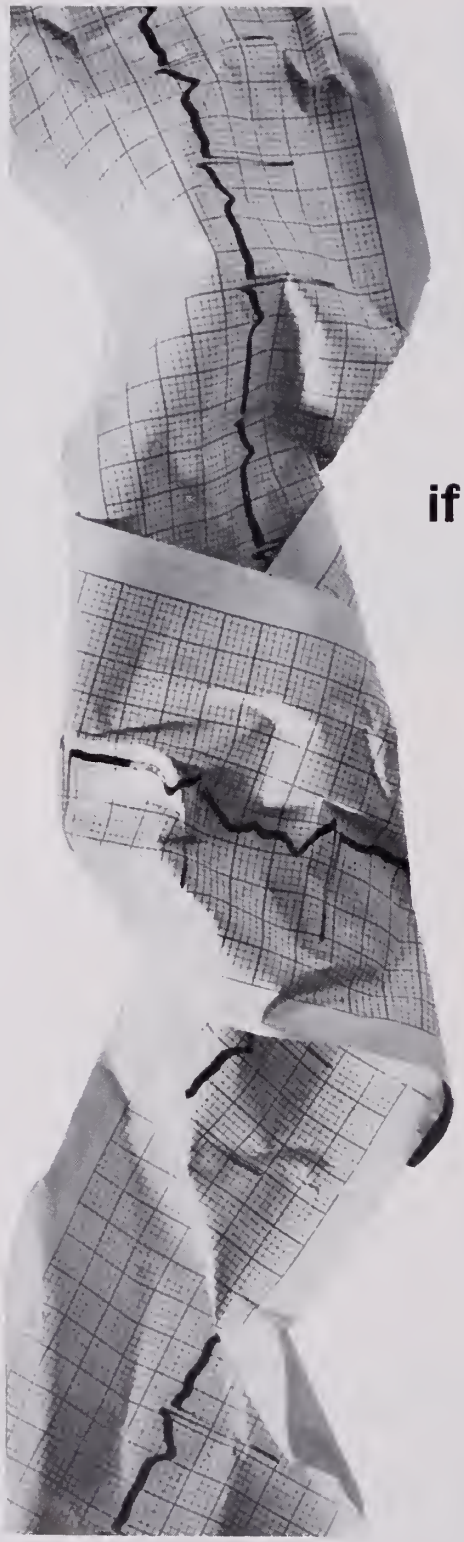

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COUNTY SOCIETY PROCEEDINGS

BROWN

The Brown County Medical Society met at the Northland Hotel, Green Bay, on March 12. After the dinner, *Dr. G. S. Kilkenny*, professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee, spoke on "Moral Aspects of Gynecology."

DANE

The regular March meeting of the Dane County Medical Society was held March 10 at the State Medical Society building, Madison. *Dr. J. K. Scott*, Madison, reported on "Contribution of the American Cancer Society to Medical Research." Robert A. Ragotzkie, Ph.D., associate professor of meteorology, University of Wisconsin, Madison, spoke on "Lakes and Living in the Antarctic."

The following are new members of the Society.

Dr. Klaus Backwinkel was born at Unna, Germany. He graduated from the Munich University Medical School in 1953 and served his internship at the University of Muenster and at Muhlenberg Hospital in Plainfield, N. J. He completed his surgical residency at New Jersey Sanatorium and at St. Peter's Hospital in New Brunswick, N. J. Doctor Backwinkel is a new member through transfer from the Middlesex County Medical Society of New Jersey.

Dr. John F. Batson comes from McLean, Tex., and received his medical degree from Baylor University College of Medicine in 1957. He completed his internship at the University of Wisconsin and currently is a surgical resident at University Hospitals, Madison.

Dr. Robert C. Hickey was born at Hallstead, Pa., and graduated from Cornell University Medical College in 1942. He served his internship at University Hospitals, State University of Iowa. He completed his surgical residency at State University of Iowa and at Memorial Hospital for Cancer and Allied Diseases in New York City. Doctor Hickey currently is professor and chairman of the Department of Surgery at the University of Wisconsin Medical School.

Dr. Paul N. Gohdes is a native of Wausau, and received his medical degree from the University of Wisconsin Medical School in 1960. He served his internship at Rockford Memorial Hospital in Rockford, Ill. At the present time, Doctor Gohdes is in resident training for pathology at the V. A. Hospital in Madison.

Dr. Dayton H. Hinke was born at Chippewa Falls and graduated from the University of Pennsylvania Medical School in 1944. He served in the Armed Forces for two years and was in private practice in Richland Center for five years. Doctor Hinke currently is in resident training in radiology at University Hospitals, Madison.

Concerning the Sabin On Sunday Program, sponsored by the Dane County Medical Society, final figures resulting from the January 12 clinic reveal that over 203,000 doses of Type I Sabin Oral Vaccine were administered. The second clinic, held on February 23, showed 210,000 doses of vaccine administered.

Physicians whose names appear in italics are members of the State Medical Society.

DOUGLAS

The Douglas County Medical Society met in Superior on February 5. A sound movie on "Current Concept of Bronchial Asthma and Its Management" was shown. New members accepted into the Society are *Dr. C. M. Scott*, Superior, *Dr. Robert Mann*, Superior, and *Dr. John Knights*, Superior.

The March 4 meeting held in Superior featured Dr. John Banovetz, University of Minnesota, who spoke on "Maxilla—Facial Injuries."

EAU CLAIRE–DUNN–PEPIN

The Eau Claire–Dunn–Pepin County Medical Society met in Eau Claire on February 24. Warren Knowles, New Richmond, was the featured speaker. Mr. Knowles spoke on "Operation X-Ray of Wisconsin Government."

KENOSHA

The Kenosha County Medical Society met at the Elks Club in Kenosha in March. *Dr. M. J. Cicianelli*, Milwaukee internist, presented the scientific program.

LA FAYETTE

At a meeting of the LaFayette County Medical Society January 27, the following officers and delegates were elected: president, *Dr. L. J. Unterholzner*, Blanchardville; vice-president, *Dr. David F. Ruf*, Darlington; secretary-treasurer, *Dr. Lyle L. Olson*, Darlington; delegate, *Dr. N. A. McGreane*, Darlington; and alternate delegate, Doctor Olson.

ONEIDA–VILAS

The Oneida–Vilas County Medical Society met in Rhinelander on February 12. Election of officers was held. They are *Dr. George F. Pratt*, Rhinelander, president; *Dr. Vernon Bartley*, Eagle River, vice-president; *Dr. Marvin Wright*, Rhinelander, secretary-treasurer and delegate; and *Dr. Henry Ashe*, Minocqua, alternate delegate.

Dr. Charles H. Flint, Minocqua, was accepted into the Society as a new member.

PIERCE–ST. CROIX

The Pierce–St. Croix County Medical Society met at the Hotel Walvern, River Falls, on February 18, it was reported by *Dr. P. H. Gutzler*, River Falls, secretary.

COUNTY SOCIETY PROCEEDINGS *continued*

PRICE–TAYLOR

The Price–Taylor County Medical Society met in Phillips on February 29. *Dr. R. D. Sautter*, Marshfield, spoke on "Cardiac Pacemaker," and *Dr. N. A. Moffat*, Marshfield, spoke on "Bladder Infections in Children."

RICHLAND

The Richland County Medical Society met in Richland Center on March 5. Judge Leo Lownik, Richland County judge, and Lewis Kolhn, Richland County welfare director, discussed "Certain Welfare Problems."

SAUK

The Sauk County Medical Society met on March 10 in Baraboo. *Dr. Robert J. Samp*, Madison, spoke on "Prevention of Cancer: 40 Possible Means."

TREMPEALEAU–JACKSON–BUFFALO

The Trempealeau–Jackson–Buffalo County Medical Society met February 25 in Independence. Glenn C. Waldschmidt, State Medical Society regional representative, was the featured speaker.

WAUPACA

The Waupaca County Medical Society met in New London on February 27. *Dr. Ralph O. Kennedy*, Appleton, spoke on "Whiplash Injuries." During the business session, the Society approved the live polio vaccine clinic, immunization clinic, and rheumatic fever clinic.

WOOD

The Wood County Medical Society met in February in Marshfield. The featured speaker at the meeting was *Dr. William F. Schorr*, Marshfield, who discussed tropical diseases.

WAUKESHA

The Waukesha County Medical Society heard Dr. Charles Marks, associate professor of surgery, Marquette University School of Medicine, talk on "Management of Massive Gastrointestinal Hemorrhage," at the January 8 meeting.

The February 5 meeting was held at the Avalon Hotel, Waukesha. The speaker was Dr. Edwin A. Azen, Department of Internal Medicine, University of Wisconsin Medical School, Madison. Doctor Azen spoke to the Society about the treatable hematological disorders with emphasis on the ones which are diagnosable by the average physician with good training and with readily available laboratory facilities. During the business meeting, *Dr. J. R. Bischel*, Waukesha, reported on the Sabin program. The first clinic day was March 5. The second one will be April 26.

Because members had expressed considerable interest in the increasingly important legal aspects of medical practice, the State Medical Society arranged for Milwaukee attorneys Kluwin and Hankin to address the County Society on March 4 at the Avalon Hotel, Waukesha. They discussed "res ipsa loquitur" and its recent application to Wisconsin law. Other matters of medicolegal interest were reviewed and general discussion ensued.

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SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society held its February meeting at the University Club, Milwaukee. A panel composed of *Drs. Samuel Blankstein, A. C. Kissling, Jr., Herbert Giller,* and *Brian McLaughlin,* all of Milwaukee, discussed "Diagnosis and Treatment of Vertical Muscle Anomalies."

The March meeting featured Dr. Bruce Proctor, professor of otolaryngology, Wayne State University, Detroit, Mich., who spoke on "Advances in Tympanoplasty."

Wisconsin Association of Medical Technologists

Several Wisconsin physicians participated in the spring convention of the Wisconsin Association of Medical Technologists which was held in Madison at the Park Motor Inn on April 17–19.

On Friday, April 17, Dr. Archie MacKinney, clinical investigator, V. A. Hospital, Madison, and Miss Alice Thorngate, M. T. (ASCP), associate professor of medical technology, University of Wisconsin, presented a workshop on "Hematology." Dr. G. Phillip Hicks, instructor in medicine, University of Wisconsin Medical School, conducted a workshop in "LDH Isoenzymes."

The following presented papers at the Saturday session: Dr. Robert F. Schilling, Madison; *Dr. Thomas Geppert,* Madison, on "Hemolytic Disease of the Newborn"; Dr. Harold Deutsch, Madison, on "A Look Inside the Stomach With a Gastro-Camera"; *Dr. James Cherry,* Madison, on "Newer Viral Exanthemas"; and *Dr. Edgar Gordon,* Madison, on "Peculiar Things About Fat People." *Drs. Etheldred Schafer* and *Dean Connors,* both of Madison, were the moderators. Dr. Robert Coye, Madison, pathologist at University Hospitals, was the featured banquet speaker.

Milwaukee Academy of General Practice

Dr. Eugene Kay, Milwaukee, was elected president-elect of the Milwaukee Academy of General Practice for 1964 at the meeting of the Academy held in February. He succeeds *Dr. John A. Kelble,* Milwaukee, who took over as president. Named to the board of directors were *Drs. Samuel Sweet* and *John Schelble,* Milwaukee. *Dr. Anthony J. Sanfelippo,* Milwaukee, was named to a three-year term as a delegate to the Wisconsin Academy of General Practice.

Dodge County Medical Assistants Society

The Dodge County Medical Assistants Society met in February in Beaver Dam. "Importance of the History and Physical Examination" was presented by the guest speaker, *Dr. G. G. Drescher,* Beaver Dam. *Dr. W. J. Egan,* Milwaukee, president of the State Medical Society, and Miss Edith Murphy, president of the Wisconsin State Medical Assistants Society, began the program with respective welcome addresses. "Medical Terminology" was presented by Mrs. Elizabeth Regan, assistant professor of nursing, University of Wisconsin, Milwaukee, and Miss Gene H. Smith, Milwaukee Institute of Technology, concluded her topic of "Anatomy" with a quiz for each of the registrants. Following a noon luncheon, William D. Coder, Ph.D., spoke on "Your Chapter's Health—Prolific or Paralytic?". Doctor Coder is director of conferences and institutes at the University of Iowa, Iowa City.

Physicians whose names appear in italics are members of the State Medical Society.

Wisconsin State Society of American Medical Technologists

The quarterly meeting of the Wisconsin State Society of American Medical Technologists was held in February at the Waupaca Country Club, Waupaca. Attorney Richard E. Johnson, Waupaca, and *Dr. Pearse Meighan,* Appleton pathologist, were the speakers at the meeting.

Milwaukee Gastroenterological Society

Dr. Charles Sherkow, Milwaukee, has been elected president of the Milwaukee Gastroenterological Society. Other new officers are *Dr. Edward Levy,* vice-president, and *Dr. P. J. McNamara,* secretary-treasurer.

Alpha Omega Alpha

The University of Wisconsin Alpha Omega Alpha Honorary Medical Fraternity presented its annual lecture on March 6, at the Medical Center. Dr. Osler L. Peterson, visiting professor of preventive medicine, Harvard Medical School, spoke on "Heirlooms of the Family Doctor," studies of the quality of medical practice.

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features the following new books and new editions in their full page advertisement appearing elsewhere in this issue:

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HOBBIES FOR HEALTH

Dr. Howard Lee Gives Wild Bird Photos to CESF

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■ THE PHRASE "he's for the birds" took on a different meaning recently at the State Medical Society headquarters in Madison, when Dr. Howard Lee, Milwaukee, contributed a series of photographs to the Charitable, Educational and Scientific Foundation of the Society .

Doctor Lee, an internist, spends free hours stalking the haunts of many a wild bird with a camera, equipped with a telephoto lens. In the series of 14 carefully selected photographs donated to the CES Foundation, the patient doctor has furnished the photograph enthusiast, art lover, and bird fancier with every imaginable pose, from several fine specimens of birds in flight, to what appears to be an "Obstetrical Consultation" on the part of three storks gathered around a crude nest.

Though Doctor Lee often tramps through marshes and ponds alone, he has been known to take a companion with him. Taking cover like any hunter, he sets his sights on a particular group of birds while his companion circles the area. Then with noise or simply exposure, his companion startles the birds into action that may result in one of the photos, *if* all the variables are accounted for.

For every finished photograph, Doctor Lee states that there are probably 50 negatives in the wastepaper basket. No duck hunter ever had more devotion and it's doubtful if any hunter was ever as successful at capturing for everyone the beauty, poetry, and grace of a bird in motion.

Doctor Lee is by no means a novice in photography. He has won the *Milwaukee Journal* snapshot contest and took second place prize of $500 for black and white photography in the National Newspaper contest held yearly in Washington.

Not without humor the photographer has penned titles to most of the pictures, the aforementioned "Obstetrical Consultation" being one of them. Another, that of an owl, settled securely on a fence post is called "Legal Counsel."

Doctor Lee has indicated that the Foundation may sell any of the photographs for $25 and he will then replace them for the Foundation exhibit, free of charge.

With this arrangement, the display can be seen and appreciated in its entirety at all times by viewers, and still be available for purchase. Proceeds from the sale will go to assist the many projects sponsored by the CES Foundation, among them the Medical Student Loan Program, the Museum of Medical Progress in Prairie du Chien, Speakers Service program and many others.

The CES Foundation of the Society was created in 1954 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Doctor Lee's contribution to the Foundation represents not only a permanent collection of photographic art, but a potential source of helpful funds and reflects the ingenuity typical of many such contributions.

The photographs will be on display at the State Medical Society until next June when they will be available for loan to County Societies.

OBSTETRICAL CONSULTATION

NEWS OF WISCONSIN PHYSICIANS

Dr. Krohn Takes Tour

Dr. Robert Krohn, Black River Falls, recently took a Pan American Medical Association tour of some of the Latin American and South American countries and some of the islands of the Caribbean. The tour started from New York City and lasted two weeks.

Dr. Thompson Has Own Practice

Dr T. N. Thompson, Jr., Neillsville, recently left the Neillsville Clinic, Neillsville, to practice medicine independently in Neillsville. Doctor Thompson joined the staff of the Clinic in 1953.

Dr. Middleton Heads Board

Dr. William S. Middleton, former dean of the Wisconsin Medical School, has been named head of the newly formed drug research board of the National Academy of Sciences. The board plans to serve as an advisory body to government agencies and private organizations with responsibilities related to research on drugs. One of its projects will be to air research problems, bringing such problems to the "attention of the scientific community." Doctor Middleton served as dean of the medical school for 43 years, retiring in 1955. He then served as chief medical director of the Veterans Administration. In 1963 he became visiting professor of medicine at the University of Oklahoma.

Dr. Sneed Named Ophthalmology Fellow

Dr. Robert J. Sneed, Ashland, is now a fellow of the American Board of Ophthalmology. He is a 1957 graduate of the University of Wisconsin Medical School.

Howard Baker Awarded Fellowship

Howard S. Baker, a junior from Wauwatosa in the University of Wisconsin Medical School, Madison, has been awarded a $1,449 fellowship to work next summer at a mission hospital in Southern Rhodesia. He is one of 29 American medical students who have been awarded Smith Kline & French Laboratories foreign fellowships by the Association of American Medical Colleges. He is the son of *Dr. Vance La Mar Baker,* Wauwatosa.

Dr. Apell Speaks to PTA

Dr. Melvin G. Apell, Oshkosh pediatrician, spoke recently to the Longfellow PTA, Oshkosh. Doctor Apell discussed the changes in communicable diseases which have occurred the past few years due to the development of preventive measures and new drugs.

Dr. Edwards Announces Retirement

Dr. A. C. Edwards, Baraboo, has announced his retirement from the practice of medicine after 40 years in Baraboo. Last year, Doctor Edwards was honored by the State Medical Society and St. Clare Hospital, Baraboo, for his 50 years in the practice of medicine.

Dr. Dibble Speaks on Tanganyika

Dr. John Dibble, Eau Claire, was the featured speaker recently at the Chippewa Falls Rotary Club. Doctor Dibble was a missionary doctor in Tanganyika, South Africa, for a year and a half. He showed movies and slides of some of his experiences.

Dr. Reslock Addresses Kiwanis

Dr. C. P. Reslock, Waupun, spoke recently to the Kiwanis Club of Waupun. He discussed medical care for the aged.

Thorp Secures New Doctor

Dr. James Connolly, Merrill, has announced that he will set up a medical practice in Thorp in June. At present, he plans to rent the office and residence formerly occupied by Drs. Philip and Eleanora Jorgensen.

Dr. Wolf Honored

Dr. R. C. Wolf, Hales Corners, was honored recently by St. Luke's Hospital staff. He was one of six doctors, each of whom was recognized for more than 30 years of service to the hospital.

Grant to Dr. Vermund

The National Cancer Institute, a federal agency, recently awarded a $265,150 grant to the University of Wisconsin. The radiotherapy research award was given to *Dr. Halvor Vermund,* department of radiology, University of Wisconsin Medical School.

Dr. Sabado Named Diplomate

Dr. Ernesto F. Sabado, Janesville, has been named a diplomate of the American Board of Pathology. He is on the staff of Mercy Hospital, Janesville, as associate pathologist and director of clinical laboratories. Doctor Sabado is also certified by the American Board of Pathology.

Dr. James to Menomonie

Dr. John James has announced his move to the Red Cedar Clinic, Menomonie, in March. Doctor James formerly practiced in Middleton.

Physicians whose names appear in italics are members of the State Medical Society.

New ACOG Fellows and Candidates

New fellows from Wisconsin elected to the American College of Obstetricians and Gynecologists (ACOG) are: *Dr. Paul H. Biever*, Milwaukee; *Dr. John R. Flanary*, Wauwatosa; *Dr. Paul S. Messinger*, Milwaukee; *Dr. Ronald W. Olson*, Madison; *Dr. Eugene H. Raney*, Appleton; and *Dr. E. Y. Strawn*, Milwaukee. New candidates are *Dr. John C. Ellis, Jr.*, Madison; *Dr. Hugh Peter Rafferty*, Kenosha; and *Dr. Walter R. Schwartz*, Wauwatosa.

Dr. Brose Joins Falls Medical Group

Dr. Merle L. Brose, formerly of Irwin, Pa., has joined the Falls Medical Group, Menomonee Falls. A graduate of the University of Wisconsin Medical School, Doctor Brose practiced in Irwin for 13 years.

Dr. Lifschutz President of Staff

Dr. L. M. Lifschutz, Racine, has been elected to a two-year term as president of the medical staff at St. Mary's Hospital, Racine. Other officers are *Dr. William Kreul*, vice-president, and *Dr. T. W. Dorman*, secretary, both of Racine.

Sheboygan Clinic Officers

The following officers were reelected for the year 1964 at the Sheboygan Clinic, Sheboygan: *Dr. L. M. Simonson*, president; *Dr. R. A. Wood*, vice-president; *Dr. P. B. Mason*, secretary-treasurer; and *Drs. J. W. McRoberts, E. G. Schott, W. G. Huibregtse*, and *R. M. Senty*, directors.

Former Wisconsinite Becomes Director

Dr. James V. Lowry, assistant surgeon general of the Public Health Service and chief of the Bureau of Medical Services, recently has become director of the California Department of Mental Hygiene, it was announced by Dr. Luther L. Terry, Surgeon General. Doctor Lowry, a native of Milwaukee, is a 1937 graduate of the University of Wisconsin Medical School, Madison.

Marshfield Physicians Pass Boards

Three Marshfield Clinic physicians recently passed their specialty board examinations. They are *Dr. George L. River*, internal medicine; *Dr. Fred W. Fletcher*, internal medicine; and *Dr. Rudolf A. Pyka*, orthopedic surgery.

Dr. Hildebrand Addresses Kiwanis

Dr. William B. Hildebrand, Menasha, addressed the Kiwanis Club of Neenah in February. He attacked medicare, the King–Anderson bill, and advocated plans for medical care for the aged under the Kerr–Mills law.

U-W Distinguished Alumnus

Dr. Roy Hertz, chief of the endocrinology branch, National Cancer Institute, Bethesda, Md., has been named to receive the University of Wisconsin Medical School's Distinguished Alumnus Award for 1964. Doctor Hertz will accept the award at the Medical School's annual Alumni Day, May 22, in Madison. The award is given for distinguished contributions to medical science. His research has led to successful treatment of choriocarcinoma, and related tumors, which had been considered incurable. Doctor Hertz retrieved methotrexate, which has value in treatment of malignancies. He received B.A., Ph.D. and M.D. degrees from the University of Wisconsin.

Dr. Baertsch Named Chief

Dr. L. M. Baertsch, Hayward, was elected to head the medical staff of the Hayward Area Memorial Hospital at its annual election in February.

Dr. Boger is Diplomate

Dr. J. Neil Boger, Marshfield pathologist at St. Joseph's Hospital, has been named a diplomate of the American Board of Pathology. Doctor Boger, a native of Lebanon, Pa., received his medical degree from the University of Rochester School of Medicine in Rochester, N. Y., and had a rotating internship at Pennsylvania Hospital, Philadelphia. His residency in pathology was divided between Strong Memorial Hospital, Rochester, and St. Joseph's, Marshfield.

Dr. Hickey Speaks at Marshfield

Dr. Robert Hickey, professor of surgery and chairman of the Department of Surgery, University of Wisconsin Medical School, Madison, spoke on "Ulcerative Colitis" at the February meeting of the Marshfield Clinic Foundation, Marshfield. The program chairman was *Dr. Richard D. Sautter*, Marshfield.

Hospitals Share Clinic Day Program

A combined clinic day program on the menopause was held in February by St. Luke's, St. Francis, and Trinity Memorial hospitals, Milwaukee. Dr. George W. Mitchell, Jr., professor and chairman of the department of obstetrics and gynecology, Tufts University Medical School, Boston, Mass., Dr. J. Donald Woodruff, associate professor of obstetrics and gynecology, Johns Hopkins University Medical School, Baltimore, Md., Dr. Robert N. Rutherford, chief of obstetrics and gynecology, Virginia Mason Hospital, Seattle, Wash., and *Dr. Richard F. Mattingly*, professor and chairman of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee, were the featured speakers.

Medicare Discussed Pro and Con

Dr. Nathan Davis, Jr., Manitowoc, and Mr. John Schmitt, state vice-president of AFL–CIO unions,

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*has been reported after use of HYDROMOX Quinethazone in recent studies of patients with various hypertensive diseases, including essential hypertension and hypertension associated with arteriosclerotic heart disease, obesity. and renal disease.[1,2] The treatment period in one study was eight weeks[1] and in the other, twelve.[2] The lack of serious disturbances in serum electrolyte levels, particularly of potassium, was noteworthy and was considered a sufficiently important factor in treatment value to give the drug a preferential status.[2] One to two 50 mg. tablets once daily is usually sufficient.

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1. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, Calif., Nov. 25-28, 1962.
2. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc:* 11:945 (Oct.) 1963.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects, sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

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staged an expository debate as the feature of the February meeting of the Eagles Club, Manitowoc. Doctor Davis presented the physicians' objections to medicare plans and Mr. Schmitt, of Milwaukee, told of benefits to the aged persons. Each was allowed a rebuttal period and members of the audience took part in a spirited discussion afterwards.

Dr. Twohig On Medicare

"Medicare would not cover 25 per cent of an individual's medical bills," *Dr. David J. Twohig, Jr.*, Fond du Lac, told members of the Optimist Club recently in Fond du Lac. Doctor Twohig called the medicare plan "the beginning of complete socialism."

Dr. Larme Speaks on Heart Attacks

Dr. Francis P. Larme, New Holstein, recently spoke to the Kiwanians of New Holstein. The theme of his talk was heart attacks.

Dr. Gass is Health Officer

Dr. Howard Gass, Milwaukee, has become the new health officer for Franklin. He replaces *Dr. R. C. Wolf*, Hales Corners, who resigned recently after 34 years of service.

Dr. Duser Speaks to Nurses

Dr. Arthur Van Duser, Madison, spoke to the Middleton Registered Nurses Club recently. He discussed venereal diseases.

Dr. Sisk Addresses Group

Guest speaker at the meeting of the Fond du Lac Medical and Dental Assistants, in February, was *Dr. James A. Sisk*, Fond du Lac. Doctor Sisk, who is anesthesiologist at St. Agnes Hospital, outlined the history of anesthetics, the different kinds, and their uses.

Dr. Holt Discusses Atomic Energy

Dr. Steven Holt, Kenosha, recently discussed atomic energy to the Congregational Men's Club, Kenosha. Doctor Holt is pathologist and director of laboratories at Kenosha Memorial Hospital.

Dr. Schwab Addresses Nurses

Dr. Robert L. Schwab, director of the laboratory and pathology departments of Theda Clark Memorial Hospital, Neenah, spoke recently to the Appleton District Nurses Association. He discussed new laboratory techniques, the role of the laboratory in medicine in the hospital and general practice of medicine, its past, present and future. Doctor Schwab is a graduate of the University of Kansas. He interned at St. Mary Hospital, Duluth, Minn.; served in the U. S. Army Medical Corps as a major and practiced general medicine at Marion before entering the specialized field of pathology. Training in pathology at a V. A. Hospital, St. Mary Hospital, and Marquette University School of Medicine preceded his licensing as a certified pathologist in 1955. He has been at Theda Clark Memorial Hospital since then.

Dr. Stiles Addresses Woman's Club

Dr. Frank C. Stiles, Monroe, discussed "Juveniles and Their Problems" at a recent meeting of the Burlington Junior Woman's Club. Doctor Stiles illustrated his remarks by exhibiting actual weapons taken from juveniles in Wisconsin.

Dr. Fisher Appointed

Dr. H. E. Wilkinson, director, Tomah Veterans Administration Hospital, has announced the appointment of *Dr. Albert L. Fisher*, La Crosse psychiatrist, as consultant to the V. A. Hospital. Doctor Fisher will also continue in private practice in La Crosse. He is a diplomate of the American Board of Psychiatry and Neurology.

Dr. Kleppe Heads 1964 United Givers Budget

Dr. L. W. Kleppe, Beloit pathologist, has been appointed as chairman of the 1964 United Givers Fund's budget and admissions committee. A Beloit resident since May, 1960, Doctor Kleppe is a native of Bismarck, N. D. He has a B.S. degree from the University of Nebraska and an M.D. from its college of medicine. He is a fellow of the American Society of Clinical Pathology and a diplomate of the American Board of Pathology.

Dr. Pollard is Staff Head

Dr. W. H. Pollard, Jr., Beloit, has been named president of the medical staff of Beloit Memorial Hospital, Inc. He succeeds *Dr. R. J. Sanderson* as head of staff. Other officers are *Dr. F. K. Johnson*, president-elect, and *Dr. G. C. Matthews*, secretary-treasurer. In addition to the four officers, the executive committee of the medical staff also includes *Drs. C. M. Carney, John L. Babb* and *William A. Pruett*, all of Beloit.

Dr. Gallagher Addresses PTA

Dr. William Gallagher, member of the staff of the Skemp Clinic, La Crosse, spoke at the Hokah, Minn., PTA meeting in March. He described his experiences and showed pictures taken while serving on the Good Ship HOPE.

New Schrank Clinic Opens

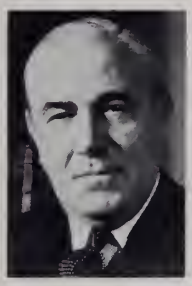
The new Schrank Clinic was opened early in March by three Waupun physicians, *Dr. Leonard W. Schrank, Dr. Raymond E. Schrank* and *Dr. William J. Petters. Dr. William A. Wagner*, who has been with the clinic, has remained in the former Schrank building.

Dr. Burhani Certified

Dr. A. Walid Burhani, Kenosha, was certified recently by the American Board of Surgery.

Gundersen Visiting Professor

Sir John Bruce, Regius Professor of Clinical Surgery, at the University of Edinburgh, will be the Gundersen Visiting Professor of Surgery at the University of Wisconsin Medical Center, Madison, during the week of May 3 as a guest of the Surgery Department.



Sir John Bruce

During his week in residence, Professor Bruce will actively participate in resident and medical student teaching. On Wednesday afternoon, May 6, at 4:30 o'clock, Sir John will deliver a lecture on "The Therapy of Breast Cancer in Scotland" to the surgeons of Wisconsin in Room 227 of the Medical School's Service Memorial Institutes. On Thursday, May 7, which is also the annual Medical School Field Day, Sir John will address the medical students at 2 p.m. in Room 227 S.M.I. His topic will be "A Surgeon's Heritage." Sir John will hold other discussions during the week on such topics as "Simple Lesions of the Colon" and "Selected Surgery of Duodenal Ulcer" for the students.

Sir John, one of the most distinguished surgeons in the Western Hemisphere, is the Senior Surgeon, Royal Infirmary of Edinburgh, and Honorary Surgeon to Her Majesty the Queen in Scotland. In addition to being a fellow of the Royal College of Surgeons of Edinburgh, he is an honorary member of the American Surgical Association; an honorary fellow of the American College of Surgeons and an honorary fellow of the surgical associations of Malaya and South Africa.

The Gundersen Visiting Professorship was established and is maintained by gifts from the Adolf Gundersen Medical Foundation, La Crosse.

New Clinic Planned

A new clinic is planned by *Drs. R. A. Kjentvet, R. D. Wichmann,* both of Wild Rose, and Dr. S. L. Hadden, currently of Florida, but expected in Wild Rose soon. It will be located on land near the Wild Rose Hospital and will be called the Wild Rose Clinic.

Dr. Sun Opens Practice

The Siren Memorial Hospital, which had been closed for several months, has reopened with Dr. Kwoh Cheng Sun beginning his practice in Siren. Doctor Sun is a graduate of the Second Shanghai Medical College in China. His period of internship was secured in Samaritan Hospital, New York City, and residency was begun in University Hospital, Seattle, Wash., and continued in Methodist Hospital, Peoria, Ill. Doctor Sun came to Siren from Peoria to begin his first private practice.

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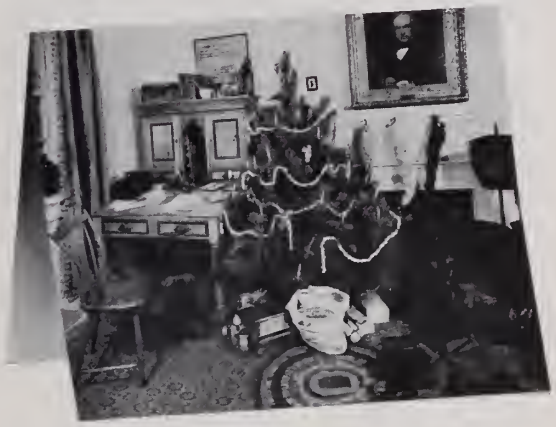

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Wisconsin's Representative to WMA

Dr. Marvin H. Olson, Schofield, is pictured above receiving congratulations on his recent reappointment as Wisconsin State Chairman for the U. S. Committee, World Medical Association. With Doctor Olson (center) are Dr. Gerald D. Darman (left), secretary-treasurer of the Committee, and Dr. Austin Smith (right), National Committee chairman.

Dr. Love Added to Staff

Dr. Robert G. Love, Cuba City, has now become attached to the General Hospital, Prairie du Chien. He is a graduate of the University of Maryland Medical School, and served his internship and as general practitioner at the Salem Hospital, Salem, Mass. He was with the Cuba City Medical Center and clinic prior to his move to Prairie du Chien.

Dr. Friedrichs Associates With Clinic

Dr. Edward S. Friedrichs, Wauwatosa, has become associated with the Clinic of Internal Medicine in Wauwatosa. He also teaches part time at Marquette University School of Medicine. Doctor Friedrichs is a 1954 graduate of Oberlin College, Oberlin, O., and received his M.D. from Northwestern University, Evanston, Ill. His internship was at the Minneapolis General Hospital, Minneapolis, Minn., and he took graduate work in internal medicine at the University of Washington and the University of Wisconsin. Graduate work in psychosomatic medicine for one year was taken at the University of Cincinnati.

March of Dimes Grants to U-W

Support for the Birth Defects Clinical Study Center at the University of Wisconsin Children's Hospital, Madison, has been renewed by the National Foundation March of Dimes with a grant of $19,307 to the University of Wisconsin Medical School. Director of the Birth Defects Center since its establishment a year and a half ago is Dr. David W. Smith, associate professor of pediatrics. Dr. John M. Opitz, Madison, will be acting director from July 1964 to August 1965, while Doctor Smith will be studying human embryology with respect to congenital malformations.

Dr. Cherry is Markle Scholar

Dr. James D. Cherry, assistant professor, University of Wisconsin Medical School, Madison, has recently become a Markle Scholar in Academic Medicine, it was announced by the John and Mary R. Markle Foundation of New York. He is one of 25 Markle Scholars in Academic Medicine whose appointments began in 1964, and whose medical schools will receive $30,000 grants toward their support for the five years, 1964–1969. Doctor Cherry received his B.S. degree from Springfield College, Vermont, and his M.D. from the University of Vermont. His specialty is pediatrics.

Dr. Rusch Speaks at Founder's Day

The University of Wisconsin Founder's Day dinner, sponsored by the Alumni Association, was held recently at the Elks Club, Green Bay. Dr. Harold P. Rusch, director of the McArdle Memorial Laboratory for Cancer Research, Madison, was the featured speaker and discussed recent developments in the field of cancer research. Doctor Rusch is known nationally and internationally as a cancer research authority.

Dr. Gott Speaks on Heart Research

Dr. Vincent L. Gott, assistant professor of surgery, University of Wisconsin Medical School, Madison, and codeveloper of the new artificial heart valve which represents a major advance in open heart surgery, spoke in February to a Heart Fund educational meeting in Monroe. He spoke on "Present Trends in Open Heart Surgery." The meeting is held each year during Heart Month by the Alpha Zeta sorority which conducts the area campaign for the Wisconsin Heart Association.

Three Psychiatrists for Clinic

Three Green Bay psychiatrists have been retained as interim directors of the County Guidance Clinic on a part-time basis, it was announced recently at an executive session of the Clinic's board of directors. *Drs. Charles Wunsch, James Caffrey* and *John Gehring* will head the clinic until a full-time director is appointed, clinic board chairman *Dr. Daniel Shea* said. The former director, Dr. Fred S. Terner, who was hired on a probationary basis, resigned his post last December.

Dr. Flanagan Named Chief

Dr. C. M. Flanagan, Fond du Lac, has assumed the post as chief of staff at St. Agnes Hospital, Fond du Lac. He succeeds *Dr. L. J. Keenan* who held the position the past two years. *Dr. H. R. Thomas, Jr.*, is staff secretary, and members of the executive and joint conference committee include *Dr. H. J. Kief*, chairman and *Dr. D. J. Twohig, Jr., Dr. D. W. McCormick*, Doctor Flanagan, Doctor Thomas, and Doctor Keenan, all of Fond du Lac.

Dr. Knoedler Leaves Mosinee

Dr. William H. Knoedler, Jr., ended his practice in Mosinee to go to Kimberly and serve the Kimberly and Little Chute area. Doctor Knoedler had practiced medicine in Mosinee since 1947.

Dr. Angevine Speaks for Arthritis Fund

Dr. D. M. Angevine, professor of pathology, University of Wisconsin Medical School, Madison, spoke at the Arthritis Benefit Breakfast, sponsored by the Beloit Federation of Women, in March. Proceeds from the breakfast will be used to support the service program of the Arthritis and Rheumatism Foundation in Wisconsin.

New Physician for Necedah

Dr. Margaret A. Von Gradulewski, a native of Germany, has begun the practice of medicine in Necedah. She has been in the U. S. A. for five months, and recently obtained her Wisconsin license. Doctor Von Gradulewski is a graduate of the University of Berlin Medical School, Germany. She will also be on the staff of the Hess Memorial Hospital, Mauston.

Dr. Eckberg Addresses Nurses

Dr. R. A. Eckberg, Stevens Point, spoke in February at the regular meeting of the Stevens Point Catholic Nurses Chapter held at St. Michael's Hospital, Stevens Point. Doctor Eckberg lectured on the normal and abnormal conditions of the chest, thoracic surgery, and pre- and postoperative care.

Wisconsin Participants at ACOG

Several Wisconsin physicians will present papers at the twelfth annual clinical meeting of the American College of Obstetricians and Gynecologists (ACOG), May 16–22, at the Americana, Bal Harbour, Fla. On Friday, May 22, Dr. J. L. Ladinsky, and *Dr. Ben M. Peckham*, Madison, will present "The Size Distribution Patterns of Exfoliated Cells From Uterine Malignancy as a Means of Cancer Screening," which will be part of a Forum on Current Investigations. Included in a seminar on Female Urology will be "Surgical Injuries of the Urinary Tract and Urinary Fistulas," presented by *Dr. Richard F. Mattingly*, Milwaukee. At one of the Breakfast Conferences on Tuesday, May 19, *Dr. William P. Wendt*, Milwaukee, will present "Pseudohemophilia—Bleeding Tendencies in Obstetrics and Gynecology," and *Dr. Ralph E. Campbell*, Madison, will present "Carcinoma of the Endometrium." At a Breakfast Conference on Thursday, May 21, Doctor Mattingly will present "Gynecologic Surgery in the Aged Female."

Dr. Hutter Addresses Rotarians

Dr. Adolph M. Hutter, Fond du Lac, addressed the Fond du Lac Rotarians in February. He discussed current "Concepts Concerning the Coronary Threat."

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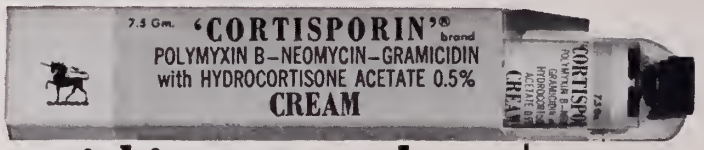

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OBITUARIES

Dr. George W. Leitch, Milwaukee, died Aug. 21, 1963, at the age of 78.

Born in Marmora, Ontario, Canada, Doctor Leitch received his medical education at Loyola University, Chicago, Ill., in 1913. He interned at Westside Hospital, Chicago, and served his residency at Central Neurological Hospital, New York.

Doctor Leitch was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

There are no survivors.

Dr. William J. Allen, Beloit, died Aug. 22, 1963, at the age of 85.

A native of Barre, N. Y., Doctor Allen was graduated from Hahnemann Medical School, Chicago, Ill., in 1901 and interned at Hahnemann Hospital. After completion of his education, Doctor Allen located in Beloit.

He was a fellow of the American College of Surgeons and a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

There are no survivors.

Dr. William Bayer, Merrill, died Aug. 23, 1963, at the age of 88.

He was graduated from the University of Illinois College of Physicians and Surgeons in 1902 and interned at Augustana Hospital, Chicago, Ill. Doctor Bayer practiced in Gleason until moving to Merrill in 1920.

He was a member of the Lincoln County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Sadie; three sons, Dr. Lester Bayer, Merrill, the Reverend Karl O. Bayer, Bryan, Tex., and David Bayer, Madison.

Dr. Eugene E. Flemming, Wausau, died Sept. 20, 1963, at the age of 71.

Originally from Mayville, Doctor Flemming received his medical education at Chicago College of Medicine and Surgery in 1914. He interned at Bridewell Hospital, Chicago, Ill., and was associated with Inland Steel Company, Indiana Harbor, Ind., before entering military service in 1917. He returned to Wisconsin after serving in the Army Medical Corps.

Doctor Flemming was a member of the American Academy of General Practice, the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Milton M. Spitz, Milwaukee, died Oct. 2, 1963, at the age of 86.

Born in Chicago, Ill., Doctor Spitz received his medical education at the Wisconsin College of Physicans and Surgcons in 1901. Following his internship at Michael Reese Hospital, Chicago, he returned to Milwaukee to practice.

Doctor Spitz was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his son, Dr. Milton B. Spitz, Milwaukee.

Dr. Charlotte B. Slotnik of Milwaukee died Oct. 29, 1963, at the age of 44. Although she was granted a Wisconsin license to practice medicine in 1960, she was not in active practice at the time of her death.

She is survived by her husband, Dr. Irvin L. Slotnik, and two daughters, Jacqueline and Deborah, of Fox Point.

Dr. John O. Muehlhauser, Sturgeon Bay, died Oct. 30, 1963, at the age of 69. He was born March 11, 1894, in Wannbach, Bavaria, Germany, to Michael Johann and Margarete Muehlhauser.

Doctor Muehlhauser studied at the Universities of Wuerzburg and Erlangen, Bavaria, Municipal Hospital, Nuernberg, and University Hospital, Erlangen, during the period from 1922 to 1931.

At Erlangen Doctor Muehlhauser was clinical assistant in both the departments of surgery and operative gynecology; at Wuerzburg, clinical assistant in the department of surgery and third assistant in the department of pharmacology and toxicology. He married Emilie Taubald on Oct. 27, 1927, in Nuernberg, Bavaria.

Doctor Muehlhauser practiced in Green Bay and West DePere as well as Sturgeon Bay from July 1926 to August 1927, since then in Sturgeon Bay.

He was medical officer in charge of the outpatient clinic for the U. S. Department of Public Health. Doctor Muehlhauser was a member of the Eagles Club having served as Eagle Doctor, American Heart Association, Selective Service Board having served 20 years, American Medical Association, State Medical Society, Door-Kewaunee County Medical Society, American Association of Surgeons, and the Society of Abdominal Surgeons.

Doctor Muehlhauser is survived by his widow; one son, Helmut Charles, St. Louis, Mo.; one daughter, Mrs. Sigrid Margarete Fencil, Monroe, and three grandchildren; one brother, Dr. Richard Muehlhauser, and one step-brother, Dr. Alfred Muehlhauser, of Erlangen and Wannbach, Bavaria, respectively. A sister and brother preceded him in death.

Dr. Seth Smith, retired Wausau physician, died Oct. 30, 1963, at the age of 88.

He was graduated from the College of Physicians and Surgeons of the University of Illinois in 1900, and located in Crandon from 1900 to 1905, at which time he moved to Wausau.

Reprinted from the APPLETON POST-CRESCENT, February 16, 1964

FOND DU LAC NATIVE

Many Hearts Heavy as Young Ski Jumping Tragedy Victim Buried

By WILLIAM C. CAREY
Past-Crescent Staff Writer

FOND DU LAC—Sorrow weighed heavily in the hearts of many this past week.

A native son, who prepared for a decade to serve humanity, was laid to rest in Rienzi Cemetery under a blanket of low, overcast skies.

His love for ski jumping had cost 32-year-old Dr. James Hanson his life.

While practice jumping with friends at Everett, Wash., Feb. 8, the young, promising orthopedic surgeon took a spill. Instead of snow, there was a patch of ice . . . and it was over.

James Hanson, M.D.

The quiet, likeable Norwegian with the friendly grin, who once talked about giving up skiing, died of a broken neck. It happened in a matter of seconds.

But behind tragedy lies a heartwarming story of a young man gifted with many talents and a strong determination which enabled him to attain his 32 years.

"Jim" Hanson was a competitor—not a star—but always determined.

While attending Goodrich Senior High School here, he competed in track, football and basketball.

One summer following the track season, young Hanson fell victim to an attack of polio. He won the battle, both in body and spirit.

Often referred to as "the brain" by his classmates, Hanson graduated in June of 1949 among the top students in his class.

That fall he left for Madison and the University of Wisconsin, skis and trombone in hand. His friends recall that "Jim" was no hepster with the horn but he knew, enjoyed and made good music.

Hanson made the "varsity" Prof. Ray Dvorak's University of Wisconsin band. He had a heavy class schedule and had to hit the books, but it didn't prevent him from pursuing competitive skiing and other activities at the "U".

His enthusiasm for skiing skyrocketed when Hanson joined the Blackhawk Ski Club and hit the tournament trail.

continued on page 43

OBITUARIES *continued*

Doctor Smith was a member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a son, David, Merrill, and a daughter, Mrs. Leon Haase, Wausau.

Dr. Kenneth J. Denys, Green Bay, died Nov. 2, 1963, at the age of 52.

A native of Green Bay, Doctor Denys was a 1938 graduate of Marquette University School of Medicine, Milwaukee, and interned at St. Mary's Hospital, Duluth, Minn.

He was a veteran of World War II, and served as captain in the U. S. Army Medical Corps in the India–Burma theater with the 151st Medical Battalion. In addition to several letters of commendation for medical care rendered under extremely trying conditions, Doctor Denys was also awarded the Soldiers Medal and the Bronze Star.

Doctor Denys was a member of the Brown County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice.

Surviving are his widow, Margaret; a son, John, Green Bay; two daughters, Mrs. Curt Weise, Pewaukee; and Linda, at home.

Dr. Charles O. Lindberg, retired former Grantsburg physician, died Nov. 11, 1963, at the age of 72.

A native of Sweden, Doctor Lindberg was a 1922 graduate of the University of Oklahoma Medical School. Following internship in Oklahoma City, Okla., he practiced medicine in Clyde, Kan., before coming to Grantsburg in 1926.

Dr. Harold G. Pudleiner, retired Algoma physician, died Nov. 25, 1963, at the age of 60.

Born in Cleveland, O., Doctor Pudleiner received his medical education at the College of Medical Evangelists, Los Angeles, Calif., in 1936. He interned and served his residency at Battle Creek Sanitarium, Battle Creek, Mich. Doctor Pudleiner owned and operated a private 14-bed hospital in Canton, Mo., before entering military service in 1941. He came to Algoma after his discharge from military service in 1946.

He was a member of the Door–Kewaunee County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice.

Survivors are his widow, two daughters, and two sons.

Dr. John W. O'Neill, a native of Dodgeville, died Nov. 30, 1963, at the age of 49.

Doctor O'Neill was a 1943 graduate of the University of Wisconsin Medical School, Madison, and interned at Luther Hospital, Eau Claire. After serving in the Army Medical Corps during World War II, he located in Menomonie, Wis. He has recently been associated with the Atomic Energy Commission, Mercury, Nev.

Dr. Benjamn H. Dike, retired Owen physician, died Dec. 10, 1963, at the age of 75.

Doctor Dike came to Owen in 1921 after a tour of the world following World War I. He served as City Health Officer for 28 years.

Survivors include his widow and two daughters.

Dr. Emory Madison Paine, Wauwatosa, died Dec. 20, 1963, at the age of 62.

A native of Grand Ledge, Mich., Doctor Paine was a graduate of the University of Michigan Medical School in 1931. Following his internship at Highland Park General Hospital, Detroit, Mich., he practiced general medicine for several years, then served his residency in psychiatry at Traverse City State Hospital, Traverse City, Mich. He served in the U. S. Army Medical Corps in the Pacific area for two years during World War II. Since November 1961, he had been clinical director of the southern division of the Milwaukee County Mental Health Center.

Doctor Paine was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Psychiatric Association, and the American Psychiatric Association.

Survivors are his widow, Helen; a son, Charles, Madison; and two daughters, Mrs. Marjorie Hicks, Cedarburg, and Susan at home.

Dr. Harry H. Prudowsky, Milwaukee, died Dec. 20, 1963, at the age of 51.

Brought to this country as an infant from Russia, Doctor Prudowsky received his medical education at Marquette University School of Medicine in 1936. He interned and served his residency at Milwaukee County General Hospital.

Doctor Prudowsky was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Vivian; a son, Mark; and two daughters, Judith and Sharon.

Dr. Harry M. Guilford, Madison, died Dec. 26, 1963, at the age of 91.

A native of Minneapolis, Minn., Doctor Guilford was a 1898 graduate of the University of Minnesota Medical School. After completion of his education he practiced in Minneapolis. In 1921 he came to Madison and became Chief of the Bureau of Communicable Diseases for the State Board of Health until he retired in 1948.

Doctor Guilford was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a son, Harry G., Green Bay.

CORRECTION. It was erroneously reported in the December 1963 issue of the *Journal* that Dr. Robert W. Kispert, of Green Bay, died on June 6, 1963. The date of Doctor Kispert's death was June 13, 1963.

HANSON continued from page 42

One winter day in the late 1950's, Hanson had a brush with death but ended up with bruises.

While jumping on the giant slide at Iron Mountain, Mich., Hanson was about to make the run when he caught a ski. It hurled him down the hill and he landed a couple of hundred feet below . . . badly bruised but nothing broken.

Veteran skiers had never recalled anyone taking such a bad spill. From his hospital bed, where he was confined for about a week, young Hanson told reporters his pride had been hurt more than himself. He talked about giving up ski-jumping.

In 1953, Hanson received his bachelor of arts degree and decided he would be a doctor. By this time, his father, Russell E., a Fond du Lac lawyer, had become a circuit judge.

(Judge and Mrs. Hanson are natives of Scandinavia in Waupaca County.)

Three years later, "Jim" Hanson graduated from the University of Wisconsin Medical School, but this was only the halfway mark.

Dr. Hanson continued his training and took his residency in orthopedic surgery at the University Hospitals at Madison from 1957–61, another four years.

He found time to pursue his favorite winter pastime on occasion and one year was physician for the U. S. Olympic ski team at Squaw Valley, Calif.

It was at University Hospitals where Dr. Hanson met an attractive, young nurse, Mary Fenske of Madison. In June of 1959 she became Mrs. James Hanson.

Then in 1961 came two years of service in the U. S. Navy with Dr. Hanson entering as a lieutenant (jg) and receiving his discharge last summer, a lieutenant commander.

Come July, and after years of study and waiting, Dr. Hanson went to Everett, Wash. to establish his practice. Home for the Hansons and two-year-old son, Robert, was at 738 Crown Dr.

Two months ago a son, John, arrived.

The doctor was busy with his practice and helping others, even up to a few hours before his untimely death. That Saturday morning he had performed a four-hour operation.

Now, as in the many years past, nothing appeared to ever ruffle this young man as he approached the twilight of life.

And then . . . came the tragic end.

(Doctor Hanson was a resident member of the State Medical Society of Wisconsin.)

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Klaus D. Backwinkel, 30 South Henry Street, Madison.
Harold J. Conlon, 8901 West Lincoln Avenue, Milwaukee.
John E. Connolly, Denmark.
Arthur B. Conrad, 1836 South Avenue, La Crosse.
Eleuterio A. de Guzman, P. O. Box 177, Wausaukee.
Edward S. Friedrichs, 6745 West Wells Street, Milwaukee.
Lance G. Glasson, P. O. Box 190, Reedsburg.
Paul N. Gohdes, 426 North Charter Street, Madison.
Robert C. Hickey, 1300 University Avenue, Madison.
Kenneth M. Klatt, 1300 University Avenue, Madison.
John R. Larsen, 430 Lily Drive, Madison.
Simon Matus, V. A. Hospital, 915 North Grand Boulevard, St. Louis 6, Mo.
James E. Ney, 2040 West Wisconsin Avenue, Milwaukee.
Larry J. Polacheck, USAH, Fort Campbell, Ky.
Francis J. Thornton, 7838 West Potomac Avenue, Milwaukee.
C. A. Villavicencio, 108 East Cook Street, Portage.
Kenneth E. Vogel, 1915 West Hampton Avenue, Milwaukee.

REINSTATED

Rudolph R. Balzer, 2040 West Wisconsin Avenue, Milwaukee.
William M. Stoll, 1551 Dousman Street, Green Bay.

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Robert Bartos, 210 East Wabash Avenue, Waukesha.
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J. H. Bultema, 4053 Stamford, Muskegon, Mich.
William T. Clark, 441 South Atwood Avenue, Janesville.
Albert S. Daniells, Arcadia, to 903 Filmore Street, Black River Falls.
Paul A. Dudenhoefer, Milwaukee, to 12535 Stephen Place, Elm Grove.
Wilson S. Dunn, 537 Holly Avenue, Madison 11.
Roland G. Evenson, Milwaukee, to 535 South 8th Avenue, Sturgeon Bay.
Alan B. Fidler, 2900 West Oklahoma Avenue, Milwaukee.
A. Yale Gerol, Kenosha, to 807-16th Street, Racine.
Lucille B. Glicklich, 5220 North Lake Drive, Milwaukee 17.
Marvin Glicklich, 5220 North Lake Drive, Milwaukee 17.
Harry Gonlag, 429 Chestnut Street, Eau Claire.
Christopher A. Graf, 1720 North 8th Street, Sheboygan.
Robert A. Gruesen, Indianapolis, Ind., to 531 Main Street, Green Bay.
Adolf L. Gundersen, 1836 South Avenue, La Crosse.
J. Edwin Habbe, 231 West Michigan Street, Milwaukee.
William L. Herner, 925 East Wells Street, Milwaukee 2.
Arvid G. Holm, Milwaukee, to 2724 North Bristol, Apt. J2, Santa Anna, Calif.
John R. James, Middleton, to Red Cedar Clinic, Menomonie.
Jerome M. Jekel, 1601 East Olive Street, Milwaukee.
William M. Jermain, 2320 North Lake Drive, Milwaukee.
Seymour L. Kaner, 2219 Garfield, Two Rivers.
William H. Knoedler, Mosinee, to 314 Kimberly Avenue, Kimberly.
C. T. Koenen, Milwaukee, to 630-18th Avenue, Lewiston, Idaho.
Thomas J. Kozina, Greenfield, to 2352 South Kinnickinnic Avenue, Milwaukee 7.
Jamil T. LaHam, Three Lakes, to 703 Linclon Street, Ripon.
Owen E. Larson, Clintonville, to 422 Broad Street, Menasha.
Robert B. Leitschuh, 5625 Washington Avenue, Racine.
John A. Lind, Rice Lake, to 5227 Wigton, Houston, Tex., 77035.
J. D. Lynch, 601 Reed Avenue, Manitowoc, 54220.
B. W. Lyne, Rochester, Minn., to Department of Pathology, Ancker Hospital, St. Paul, Minn.
I. L. Maranan, 5116 North 39th Street, Milwaukee.
Glenn E. McCormick, Elm Grove, to 10425 West North Avenue, Milwaukee.
G. D. Miller, 37880 Forrest Drive, Oconomowoc.
Robert S. Monk, 217 Wisconsin Building, Waukesha.
John J. Mulvaney, Traverse City, Mich., to 630 South Central Avenue, Marshfield.
John T. Murphy, Sturgeon Bay, to 206 South Harden Street, Columbia, S. C.
Steve R. Osicka, Amherst, to 147 North State Street, Berlin.
John U. Peters, 237 Laurel Lane, Fond du Lac.
Mitchell A. Rapkin, Rantoul, Ill., to 1153 Petra Place, Madison.
Lou Raymond, Sun Prairie, to 2351 Sherman Creels Road, Eau Claire.
Maurice J. Reuter, Sr., Mequon, to 806 East Glendale Avenue, Apt. 2, Milwaukee.
Samuel W. Rosenberg, 2309 North 49th Street, Milwaukee.
Hermann K. Rosmann, Winnetka, Ill., to Route 1, Box 188A, Hayward, 54843.
P. R. Savino, 10425 West North Street, Milwaukee, 53226.
Charles E. Schmidt, 2900 West Oklahoma Avenue, Milwaukee.
Wilfrid L. Seng, 2200 North Third Street, Milwaukee.
George M. Simon, 624 North 8th Street, Manitowoc, 54220.
Lawrence W. Smith, 114 Seventh Street, Racine.
Neil Swissman. 420 East Fairy Chasm Road, Milwaukee.
Arthur W. Tacke, 400 West Silver Spring Drive, Milwaukee, 53217.
George H. Vogt, Madison, to Hope Road, R. D. 1, Cottage Grove.
Stephen Loren Weld, 2219 Garfield, Two Rivers.
Earl F. Winter, 404 North Main Street, Oshkosh.
George S. Woodward, 9730 West Bluemound Road, Milwaukee.
Hobart H. Wright, Milwaukee, to 8026 West Wisconsin Avenue, Wauwatosa.
Richard E. Zellner, Milwaukee, to 1395 Woodlawn Circle, Elm Grove.
Alfred P. Zlatnik, 2219 Garfield, Two Rivers.

SOCIETY RECORDS *continued*

REMOVED FROM MEMBERSHIP

Clyde O. Thomas, Milwaukee County, at request of County Secretary.
M. Pinson Neal, Jr., Dane County, resigned.
Albert F. Ottow, Rock County.
Francis J. Studler, Milwaukee County, resigned.
Ralph E. Reeds, Jr., Trempealeau–Jackson–Buffalo County, resigned.

DEATHS

Herman G. Decker, Milwaukee County, January 18, 1964.
Henry Troutmann, nonmember, February 1, 1964.
O. S. Orth, Dane County, February 2, 1964.
James R. Hanson, nonmember, February 8, 1964.
May R. Wells, Dane County, February 9, 1964.
C. L. White, Iowa County, February 18, 1964.

CORRECTION

In the March 1964 Society Records, p. 36, 21 NEW MEMBERS were erroneously listed under DEATHS. The names Nonito M. Sablay, M. D., through Irving V. Wright, M. D., should have been included under NEW MEMBERS.

The names Wayne L. McFadden, M. D., through M. A. Warpinsky, M. D., erroneously listed under NEW MEMBERS, p. 35, should have been listed under CHANGES OF ADDRESS, p. 37.

Also the street address of Calvin J. Gillespie, M. D., under CHANGES OF ADDRESS, p. 37, should have been 10425 W. North St., Milwaukee, instead of 1025 W. North St. The name of L. T. Servic, which was listed under new members, p. 35, should have been spelled L. T. Servis.

The *Journal* is deeply regretful and hopes no great inconveniences were caused. Our sincere apologies.

Fifth National Cancer Conference

The Fifth National Cancer Conference will be held Sept. 17–19, at the Bellevue–Stratford Hotel, Philadelphia, Pa. It is sponsored by the American Cancer Society and the National Cancer Institute.

On the program, special attention is drawn to the Saturday morning (September 19) plenary session. This will consist of a memorable event in which five Nobel Prize winners in medical science will speak on their award winning research to the attendees of the conference, directing themselves primarily to a large audience of medical students of Philadelphia, especially invited to this part of the program.

Reservations for hotels must be in by September 1. Accommodations will be available at the Bellevue–Stratford, Sylvania, Adelphia, Benjamin Franklin, and Warwick Hotels. Preregistration as soon as possible is suggested. Additional information, copies of programs, reservation and registration cards may be obtained from the Wisconsin Division of the American Cancer Society, Box 1626, Madison, Wisconsin 53701.

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1964 **Wisconsin**

May 7: University of Wisconsin Medical School Field Day, Madison.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

May 12–13: Wisconsin Clinic Managers, spring meeting, Kaiser Knickerbocker Hotel, Milwaukee.

May 23: Scientific Meeting, Langlade County Medical Society, Langlade County Memorial Hospital, Antigo.

May 25: Wisconsin State Medical Golf Association, Milwaukee.

June 5–7: Wisconsin State Medical Assistants Society, 10th Annual Meeting, Clayton House, Racine.

June 9: Care of Newborn Conference, Holy Family Hospital, New Richmond.

June 10: Care of Newborn Conference, New Memorial Hospital, Superior.

June 11: Care of Newborn Conference, Langlade County Memorial Hospital, Antigo.

June 13: Wisconsin Heart Association, Annual Meeting and nurses and closed chest resuscitation seminar, Wisconsin Center Building, Madison.

June 18–20: University of Wisconsin Postgraduate Program on Community Psychiatry, Wisconsin Center Building, Madison.

June 19–Aug. 3: Cardiovascular Disease Nursing Course, Marquette University School of Nursing, Milwaukee.

July 12–Aug. 2: Diabetes Association of Greater Chicago, summer camp for diabetic children, Holiday Home, Lake Geneva, Wis.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

Oct. 15–17: American College of Obstetricians and Gynecologists, District VI meeting, Milwaukee.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

1964 **Out-of-State**

May 1: Fourth Annual Upjohn Symposium for Student American Medical Asociation's 14th Annual Meeting, Sherman House, Chicago.

May 1–2: AMA Congress on Environmental Health Problems, Chicago.

May 5–15: Postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," University of Cincinnati College of Medicine and Christ Hospital, Cincinnati.

May 9–14: American Proctologic Society and Section of Proctology of the Royal Society of Medicine, Philadelphia, Pa.

May 9: American Rhinologic Society, Samuel Iglauer Memorial Lectures, University of Cincinnati College of Medicine, Cincinnati, O.

May 11–14: 35th Annual Scientific Meeting of the Aerospace Medical Association, Americana Hotel, Miami Beach, Fla.

May 15–17: Illinois, Iowa, and Wisconsin Blood Bank Associations, Sherman House, Chicago.

May 17–22: American College of Obstetricians and Gynecologists, Twelfth Annual Clinical Meeting, Bal Harbour, Fla.

May 18: University of Illinois Medical Alumni Association, annual seminar and reunion banquet, Hotel Sherman, Chicago.

May 22: Symposium on Clinical Aspects of Acute Leukemia, sponsored jointly by American Cancer Society and the National Cancer Institute, New York Hilton, New York City.

May 22–23: Chicago Ophthalmological Society, 1964 Annual Clinical Conference, Drake Hotel, Chicago.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 1–5: American College of Physicians postgraduate course No. 17, "Recent Advances in Clinical Nutrition," Lemuel Shattuck Hospital, Boston, Mass.

MEDICAL MEETINGS

POSTGRADUATE COURSES

June 1–5: Annual Meeting of the Medical Library Association, St. Francis Hotel, San Francisco, Calif.

June 8–12: American College of Physicians postgraduate course No. 18, "Recent Progress in Endocrinology," University of Washington School of Medicine, Seattle.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

June 21–25: 113th annual convention of the American Medical Association, San Francisco, Calif.

June 22–25: Catholic Hospital Association convention, New York City.

Aug. 2–14: Israel Medical Association, 6th World Assembly, Haifa, Jerusalem, and Tel-Aviv, Israel.

Aug. 3–7: University of Colorado School of Medicine, 7th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 24–27: American Hospital Association, Chicago.

Aug. 24–28: International Conference on Preventive Cardiology, University of Vermont, Burlington, Vt.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 17–19: Fifth National Cancer Conference, Philadelphia, Pa.

Sept. 24–25: Animal Care Panel, 15th annual meeting, Hilton Hotel, New York City.

Sept. 30–Oct. 2: Florida Diabetes Association, Seminar on diabetes and related endocrine disorders, Balmoral Hotel, Miami Beach, Fla.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 26–29: National Safety Congress, Chicago.

Nov. 3–7: American Society of Oral Surgeons, Forty-Sixth Annual Meeting, Las Vegas, Nev.

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

Diabetes Association of Greater Chicago

The summer camp for diabetic children will be conducted for the sixteenth year under the auspices of the Diabetes Association of Greater Chicago from July 12 through August 2, at Holiday Home, Lake Geneva, Wis. Boys and girls from 8 through 14 years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for summer camp are arranged in accordance with individual circumstances.

Applications may be obtained from, and inquiries should be directed to: Diabetes Association of Greater Chicago, 620 North Michigan Avenue, Chicago 11, Ill., Superior 7–8842.

American Society of Oral Surgeons

The American Society of Oral Surgeons wishes to announce the presentation of a cash award at the Forty-Sixth Annual Meeting in Las Vegas, November 3–7. This award will be for superior, original, unpublished manuscripts concerning any phase of research related to oral surgery completed during the current year.

All individuals interested in this competitive award should write: American Society of Oral Surgeons, 919 North Michigan Avenue, Chicago 11, Ill.

U of I Medical Alumni Association

The University of Illinois Medical Alumni Association will hold its annual seminar and reunion banquet during the Illinois State Medical Society Meeting, Monday, May 18.

Following the seminar program, which will be held on the campus 9:00 a.m. to 4:00 p.m., the alumni will meet in the Hotel Sherman's Crystal Room from 6:00 to 7:00 p.m. for a social hour. The reunion activities will be climaxed by a banquet in the Louis XVI Room, beginning at 7:30 p.m.

Student American Medical Association

The prevention of surgical shock and the management of the condition called "irreversible" shock will be the topic for discussion by a distinguished panel of physicians at a special session of the Student American Medical Association's 14th Annual Meeting.

The panel will participate in the Fourth Annual Upjohn Symposium, scheduled in Chicago at the Sherman House on Friday, May 1, at 1:30 p.m.

The Symposia Series, sponsored by The Upjohn Company, is designed to provide SAMA members—medical students, interns and residents—with outstanding speakers on subjects of great medical importance. The proceedings of these symposia are published in THE NEW PHYSICIAN following the convention.

More than 2,000 students, interns and residents from schools and hospitals throughout the nation are expected to attend the annual SAMA meeting, which is scheduled from April 30 through May 3.

Wisconsin State Medical Golf Association

Blue Mound Country Club, Milwaukee, will be the site for the annual Spring tournament of the Wisconsin State Medical Golf Association on Monday, May 25. Tee-off time will be from 10:30 a.m. on. Luncheon will be available at the Club House from 11:00 a.m. to 2:00 p.m. It is planned to have dinner at approximately 7:30 p.m.

A reminder will be mailed to all members of the Wisconsin State Medical Golf Association with a reservation blank shortly before the tournament date of May 25. Physician golfers who are not members of the Association are invited to make reservations and to participate in the tournament. Nonmembers will be interested to know that a life membership in the Wisconsin State Medical Golf Association is $5.00. You may send your check and become a member by addressing your request to: Mr. A. H. Luthmers, Executive Secretary, at 756 N. Milwaukee St., Milwaukee, Wisconsin 53202.

The mid-summer tournament of the Wisconsin State Medical Golf Association will be held at Maple Bluff Country Club, Madison, on September 16. All physicians are also invited to participate in the annual tournament of The Medical Society of Milwaukee County which will be held August 11, at Parc-wood Country Club, Mequon.

Preventive Cardiology

The first international conference on Preventive Cardiology will be held at Burlington, Vt., August 24–28, under the auspices of the University of Vermont. Approximately 40 prominent speakers and discussants from 10 countries will be present. The Conference will focus attention chiefly on the preventable nonvascular myocardial vulnerability factors in degenerative heart disease. It will direct an appeal to governmental and private agencies for the support of research and public education in preventive cardiology, and for organized preventive action in those industrialized, prosperous countries which still do not have such programs. Inquiries should be directed to: W. Raab, M.D., president of the Preventive Heart Reconditioning Foundation, 206 Summit Street, Burlington, Vt., 05401.

Chicago Ophthalmological Society

The Chicago Ophthalmological Society will hold its 1964 Annual Clinical Conference on May 22 and 23 at the Drake Hotel, Chicago. Speakers will present papers and symposia will be held. The twentieth annual Gifford Memorial Lecture will be presented by Dr. Derrick T. Vail, Chicago, on "After Results of Vitreous Loss." The fee is $50.00, and includes roundtable luncheons and dinner following the Gifford Memorial Lecture. Registration may be made to Mrs. Arlyne R. Schulz, 5552 N. Olcott Ave., Chicago, Ill. 60656.

Illinois, Iowa, and Wisconsin Blood Bank Associations

The Illinois, Iowa, and Wisconsin Blood Bank Associations will meet jointly at the Sherman House in Chicago on May 15, 16 and 17. The program will consist of scientific speeches and exhibits in the field of blood banking. Officers of the Wisconsin Association of Blood Banks are: president, Mr. L. J. Peterson, Madison; president-elect, Dr. S. H. Holt, Kenosha; vice-president, Dr. Byron Myhre, Milwaukee; and secretary-treasurer, Mrs. Harriet Englerth, Madison.

American College of Obstetricians and Gynecologists

Nationally known authorities in the fields of medical education, hospital accreditation, and doctor-hospital relationships will be honored guest speakers at the Twelfth Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, to be held May 17–22, at Bal Harbour, Fla. The first scientific session on Monday morning will feature addresses on the general theme of "The Inter-Professional Relationships of the Obstetrician-Gynecologist." The speakers will be Dr. Leland S. McKittrick, Brookline, Mass., immediate past chairman of the Council on Medical Education and Hospitals of the A.M.A.; Dr. Kenneth B. Babcock, Chicago, director of the Joint Commission on Accreditation of Hospitals; and James E. Ludlam, LL.B., Los Angeles, Calif., legal counsel of the California Hospital Association. On Thursday morning, the opening address will be given by Dr. Robert Aldrich, director of the National Institute of Child Health and Human Development, and he will also discuss the relationship of this new NIH division to obstetrics and gynecology.

ACOG District Meetings

The American College of Obstetricians and Gynecologists (ACOG) district VI meeting on the 1964 Conference on Obstetric, Gynecologic, and Neonatal Nursing will be held October 15–17. The meeting place is Milwaukee.

M.D.'S INVITED TO SPECIAL LANGLADE COUNTY MEETING

Officers of the Langlade County Medical Society extend a cordial invitation to all physicians in the area to attend a special scientific meeting on June 6, at Langlade County Memorial Hospital, Antigo, with Dr. David Yi-Yung Hsia, professor of pediatrics at Northwestern University School of Medicine, and chairman of the Department of Pediatric Genetics at Children's Memorial Hospital, Chicago, as guest speaker.

Doctor Hsia will speak from 3:00 to 4:00 p.m. on "Erythroblastosis and Exchange Transfusions," after which there will be a coffee break, followed by a full hour when Doctor Hsia will speak on medical genetics and parent counseling.

This special program is sponsored by the Merck Sharp & Dohme Postgraduate Program and attendance of physicians is without registration fee. Following the meeting there will be a dinner in the hospital for which there will be a charge of $2.50.

Those planning to attend outside of Langlade County are requested to drop a note to John E. McKenna, M.D., 813 Fifth Avenue, Antigo, so that proper arrangements for the meeting can be made.

TENTH ANNUAL MEETING OF THE WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

CLAYTON HOUSE, RACINE, WISCONSIN

June 5–6–7, 1964

Theme: Waxing in Ways to Wisdom with WSMAS

FRIDAY, JUNE 5

P.M.
7:30 Registration
8:30 President's Conference
9:00 Executive Committee Meeting
9:30 Fellowship Activities

SATURDAY, JUNE 6

A.M.
8:30 Registration
9:00 Welcome
Miss Edith C. Murphy, President
Wisconsin State Medical Assistants Society
Welcome
Frank J. Scheible, M.D., President
Racine County Medical Society
Welcome
The Honorable William H. Beyer
Mayor, City of Racine
9:30 "The Role of Government in Health Care of the People"
George Collentine, Jr., M.D.
Milwaukee, Wisconsin
10:15 "Plastic and Maxillo Facial Surgery Highlights"
Louis Maxey, M.D., D.D.S.
Milwaukee, Wisconsin
11:15 "The Medical Profession and Law Enforcement"
Miss Marilyn Leach, Racine Policewoman

P.M.
12:15 Luncheon Honoring County Presidents
1:30 "Prescription for P-R Deficiency"
Miss Helen Mathison, Assistant Managing Editor
WISCONSIN STATE JOURNAL
Madison, Wisconsin
2:15 "Nostrums, Notions and Potions"
A. Yale Gerol, M.D.
Racine, Wisconsin
3:00 Conducted Tour of the Johnson Wax Company Office and Research Tower
6:30 Social Hour
7:30 Banquet

SUNDAY, JUNE 7

A.M.
9:30 Annual Business Meeting
Election of Officers

N.
12:00 Luncheon
Installation of Officers

P.M.
3:00 Executive Committee Meeting

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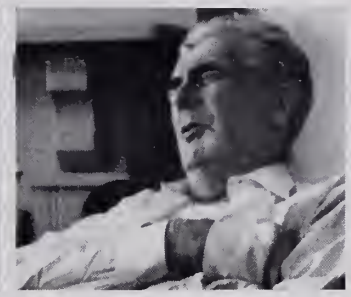
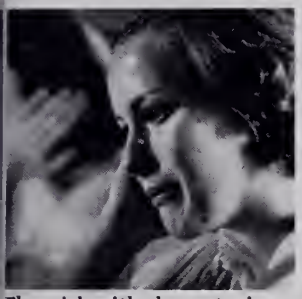
The insomniac

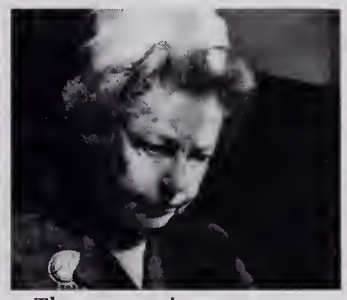
The tense, nervous patient

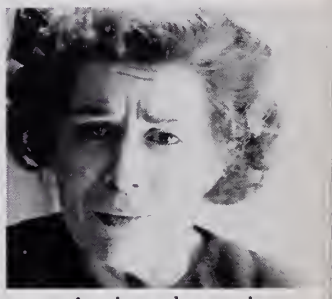

The heart-disease patient

The surgical patient


The girl with dermatosis

Tension headache


The woman in menopause


Anxious depression

Premenstrual tension

The agitated senile patient

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WISCONSIN CLINIC MANAGERS SPRING MEETING

May 12–13, 1964

Kaiser Knickerbocker Hotel, Milwaukee

TUESDAY, MAY 12

A.M.

9:30 "The Health Insurance Industry looks to us for Answers."

10:00 Open discussion, question and answer period of speaker.

10:30 "Emergency Hospital Service in the Clinic" *Vincent Meyer*, Business Manager, Sheboygan Clinic. Followed by question and answer period.
The chairman will recognize *ANY* questions from the floor covering *ANY* subject following Mr. Meyer.

11:30 Adjourn for luncheon—courtesy Pengelly X-Ray Corporation.

P.M.

2:00 Latest activities of Blue Cross—Surgical Care Blue Shield of Milwaukee County.

2:15 "Credit and Collection Trends," *Dave Miley*. Open Question period.
The chairman will recognize *ANY* questions from the floor covering any subject following Mr. Miley.

3:15 Adjournment to visit exhibits at auditorium.

Evening: Cocktail party and dinner at the Milwaukee Athletic Club, co-sponsored by Blue Cross, Surgical Care Blue Shield and Roemer–Karrer Company. (Exact time will be announced at the afternoon session.)

WEDNESDAY, MAY 13

A.M.

9:15 Call to order, announcements, etc.

9:30 Insurance activities of Wisconsin Physicians Service.

9:45 "Tips on Selection, Placement and Appraisal of Personnel", *Bill Matthews*, Personnel Director, The Marshfield Clinic. Followed by question and answer period.

11:00 Adjournment—courtesy luncheon, State Medical Society at the Milwaukee Athletic Club—cocktails and luncheon to start at 11:30 a.m.

MEDICAL MEETINGS *continued*

Graduate Program in Health and Hospital Administration

The University of Florida announces a graduate program in health and hospital administration. Applications for the first class to be held in September are now being accepted. The degree of master of business administration with a concentration in health and hospital administration will be awarded upon the successful completion of the two-year program. Inquiries for a brochure giving specific information on this new program should be directed to: Mr. L. R. Jordan, chairman, Program in Health and Hospital Administration, College of Health Related Services, University of Florida, Gainesville, Fla.

ACS-NCI Symposium on Leukemia

The American Cancer Society (ACS) and the National Cancer Institute (NCI) will sponsor a Symposium on Clinical Aspects of Acute Leukemia on Friday, May 22, at the New York Hilton Hotel, New York City. The Symposium has been planned as an experiment in medical communication and is intended to bridge the gap between laboratory research and care of the leukemia patient. One of the specific objectives of the Symposium is to interpret the findings of the research conference on "Obstacles to the Control of Acute Leukemia," held March 21–23, and draw from them practical implications and guidelines which may be applied in practice by pediatricians, hematologists, radiologists and other medical practitioners.

It will feature "Management of the Leukemia Patient and Family," by Dr. Sidney Farber, Children's Cancer Research Foundation; "Epidemiology and the Etiology of Acute Leukemia," by Dr. Robert W. Miller, National Cancer Institute; "The Role of Viruses as Etiologic Agents in Acute Leukemia," by Dr. James T. Grace, Jr., Roswell Park Memorial Institute; "Natural History and Diagnostic Peculiarities," by Dr. Carl V. Moore, Washington University School of Medicine; and "Clinical and Radiologic Diagnostic Features," by Dr. M. Lois Murphy, Sloan–Kettering Institute for Cancer Research.

SPECIAL OB NURSE TRAINING AVAILABLE

A series of intensive two-week training programs for obstetrical nurses in small hospitals has been announced by St. Joseph's Hospital, Milwaukee, which is presenting the programs in cooperation with the Marquette University School of Nursing and the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. Three such programs have already been completed. Additional training periods will be from April 20 to May 3; May 11 to 31; and June 8 to 21. Hospitals interested in participating in these programs are asked to contact John R. Evrard, M.D., 400 Bankers Bldg., Milwaukee 2, for further details. Attendance is limited, so early reservations are suggested.

"Treatment of Acute Leukemia" will be presented in three parts by Dr. Grant Taylor, Anderson Hospital and Tumor Institute, Dr. Emil Frei, III, National Cancer Institute, and Dr. Emil Freireich, National Cancer Institute. "Obstacles to the Clinical Control of Acute Leukemia," will be presented by Dr. James A. Holland, Roswell Park Memorial Institute, and "Summary and Conclusions" will be drawn by Doctor Farber.

U-W Postgraduate Program on Community Psychiatry

A University of Wisconsin Postgraduate program on "Community Psychiatry: What It Is and What It Isn't" will be presented at the Wisconsin Center Building, Madison, on June 18–20. It is presented by the Wisconsin Psychiatric Institute; Department of Psychiatry, School of Medicine; and the Division of Mental Hygiene, State Department of Public Welfare. It is an interdisciplinary conference bringing together clinician-scientists from diverse areas of inquiry. The conference will be devoted to a clarification, both theoretical and empirical, of the definition of an area of psychiatry of increasing importance.

On Thursday, June 18, Dr. Leonard J. Ganser, Associate Clinical Professor of Psychiatry, University of Wisconsin, and Director, Division of Mental Hygiene, State Department of Public Welfare, will preside over the program featuring "Theoretical Models in Community Psychiatry," by Dr. Melvin Sabshin, Professor of Psychiatry, University of Illinois College of Medicine; and "Community Psychiatry: Some Sociological Perspectives and Implications," by David Mechanic, Ph.D., Associate Professor of Sociology, University of Wisconsin.

The afternoon session, presided over by Dr. Charles W. Landis, Director of Mental Health, Milwaukee County Institutions, will feature "Some Planning and Practice Perspectives on the Boundaries of Community Psychiatry," by Alfred J. Kahn, D.S.W., Professor of Social Work, Columbia University; and "Training for Community Psychiatry in a Psychoanalytically-Oriented Department of Psychiatry," by Drs. Milton Rosenbaum and Israel Zwerling, Professor and Associate Professor of Psychiatry, respectively, Albert Einstein College of Medicine.

Presiding over Friday's morning session, June 19, will be Dr. Leigh M. Roberts, Assistant Professor of Psychiatry, University of Wisconsin. Presented will be "Evaluating Community Care for Schizophrenic Patients in the United Kingdom," by Dr. John Wing, Institute of Psychiatry, Mandsley Hospital, London, England; "Developing a Comprehensive Mental Health Program in a Metropolitan Community," by Dr. Robert Barnes, Executive Director, Greater Kansas City Mental Health Foundation; and "Problems and Potentialities of a Local Mental Health Authority," by Dr. Courtenay L. Bennett, Director of Department of Mental Health Services, Dutchess County, Poughkeepsie, N. Y.

The afternoon session presided over by Dr. Seymour L. Halleck, Associate Professor of Psychiatry, University of Wisconsin, will feaure "The Ideational Basis of a State Community Mental Health Program," by Dr. H. G. Whittington, Director, Community Health Services, State of Kansas; and "Community Psychiatry for a Million People," by Dr. Frank E. Coburn, Professor of Psychiatry, University of Saskatchewan.

The Saturday morning session, June 20, will be presided over by Dr. Kenneth H. Rusch, Assistant Clinical Professor of Psychiatry, University of Wisconsin. "Community Mental Health: The Barriers to Its Accomplishment," will be presented by Dr. Howard Rome, Professor of Psychiatry, University of Minnesota Medical School; "Community Health and Legal Responsibility," by Francis A. Allen, LL.B., Professor of Law, University of Chicago; and "Community Psychiatry: What It Is and What It Isn't," by Martin B. Loeb, Ph.D., Professor of Social Work, University of Wisconsin.

The fee for registration is $50.00, covering tuition, materials, coffee breaks, any necessary chartered transportation, and Thursday and Friday noon lunch. Check and application should be sent to the Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison, Wis. 53706. Checks should be payable to The University of Wisconsin Extension Division.

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Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

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The flexible Special Service "no fee schedule" approach differs fram the rigid *fixed* fee schedule which leaves no room for fee adjustment based on varying case complexity and time expended by the physician in caring for a patient.

State Medical Society members, through the action of the local Caunty Advisory Committees, determine what fee level is "customary, usual and reasonable."

WHAT IS A COUNTY ADVISORY COMMITTEE?

A County Advisory Committee is appointed by the president of the county medical society and meets periodically to review claims (less than one percent of total claim volume) referred to the committee by the WPS claims department.

> The Committee reviews the facts in each case and if it cancludes that the fee is proper it will advise WPS that the charges are within the intent of the "no fee schedule" principle as it applies in that medical community.

This procedure places the responsibility and the authority for determining fees where it belongs . . . with the local physician.

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY

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ANNUAL MEETING

State Medical Society of Wisconsin

MILWAUKEE AUDITORIUM
HOTEL SCHROEDER
Milwaukee

SCIENTIFIC PROGRAM

AND RELATED ACTIVITIES

Monday, Tuesday, Wednesday

MAY 11, 12, 13, 1964

House of Delegates Session

MAY 10, 11, 12, 1964

1964 Annual Meeting Timetable

SUNDAY, MAY 10

p.m.
6:00 Buffet supper for Delegates and Officers: Hotel Schroeder
7:00 First Session of House of Delegates: Hotel Schroeder

MONDAY, MAY 11

a.m.
8:00 Registration: Milwaukee Auditorium
8:30 Opening of Exhibits: Milwaukee Auditorium
9:00 Reference Committees of the House of Delegates: Hotel Schroeder
9:30 Scientific Meetings on Obstetrics and Pediatrics: Milwaukee Auditorium

p.m.
12:30 Luncheons of Alumni Association of Marquette and U. of W. Medical Schools: Milwaukee Auditorium
12:30 Scientific Luncheons: Hotel Schroeder
2:00 Scientific Programs on Obstetrics and Pediatrics: Milwaukee Auditorium
3:45 Communications on Implementation of HAPA (Kerr–Mills): Hotel Schroeder
4:00 Wisconsin Academy of General Practice, Conference and Dinner: Hotel Schroeder
5:30 Auxiliary Board of Directors Meeting: Hotel Schroeder
5:30 Special Dinner, Pediatricians and Wives: University Club, Milwaukee
7:30 Second Session of House of Delegates: Hotel Schroeder
8:00 Special Meeting on Internal Medicine: Hotel Schroeder

TUESDAY, MAY 12

a.m.
8:00 Registration and Opening of Exhibits: Milwaukee Auditorium
9:00 Third Session of House of Delegates: Hotel Schroeder
9:00 Scientific Program on "Medical Genetics": Milwaukee Auditorium (Cooperative program of Pathologists and Internists)
10:00 Business Meeting of Auxiliary: Hotel Schroeder
10:30 Meeting of the Council: Hotel Schroeder

p.m.
12:30 Scientific Luncheons: Hotel Schroeder
12:30 CES Foundation Officers and Trustees Luncheon and Annual Meeting: Hotel Schroeder
1:00 Auxiliary Luncheon: Milwaukee Athletic Club
2:00 Continuation of Scientific Program on "Medical Genetics": Milwaukee Auditorium
3:00 Wisconsin Society of Pathologists, Board Meeting: Hotel Schroeder
6:30 President's Reception (For those attending Dinner): Hotel Schroeder
7:15 Annual Dinner: Hotel Schroeder

WEDNESDAY, MAY 13

a.m.
8:00 Registration and Exhibits: Milwaukee Auditorium
9:30 Scientific Programs on Dermatology and Orthopedic Surgery: Milwaukee Auditorium
10:00 Auxiliary Business Meeting: Hotel Schroeder

(continued next column)

TIMETABLE continued

p.m.
11:30 Clinic Managers Luncheon, Milwaukee Athletic Club
12:30 Scientific Luncheons: Hotel Schroeder
12:30 Luncheon, Business Meeting and Scientific Program: Section on Ophthalmology & Otolaryngology: Milwaukee Auditorium
12:30 Past President's Luncheon: Hotel Schroeder
1:00 Auxiliary Luncheon: Stoeffers Restaurant, Top of Marine
2:00 Scientific Programs on Anesthesiology, EENT, Radiology, and Surgery: Milwaukee Auditorium
3:45 Close of Exhibits: Milwaukee Auditorium
5:00 Joint Dinner of Milwaukee Oto-Ophthalmic Society and Wisconsin Otolaryngological Society: University Club, Milwaukee
6:00 Dinner of Wisconsin Society of Anesthesiologists (and wives): Milwaukee Inn, Milwaukee
6:00 Dinner of Wisconsin Orthopedic Society (members only): Milwaukee Athletic Club
7:00 Dinner of Wisconsin Radiological Society Members (members and guests only): University Club, Milwaukee
7:00 Dinner of Wisconsin Surgical Society (and wives): Milwaukee Athletic Club

Out-of-State Guest Lecturers and Schedules

D. J. BIRMINGHAM, M.D.
Cincinnati, O.

WEDNESDAY

9:30 a.m.—Occupatianal Dermatases
12:30 p.m.—Lunchean, Dermatolagy

E. T. BOLES, JR., M.D.
Columbus, O.

MONDAY

12:30 p.m.—Luncheon, Pediatrics
2:00 p.m.—Pediatrics
3:45 p.m.—Pediatrics

W. H. BORGES, M.D.
Chicago, Ill.

MONDAY

9:30 a.m.—Pediatrics
11:15 a.m.—Panel, Pediatrics
12:30 p.m.—Luncheon, Pediatrics

B. C. BUCHTEL, M.D.
New Orleans, La.

WEDNESDAY

12:30 p.m.—Lunchean, Rodiology
2:30 p.m.—Radiology

P. A. CHANDLER, M.D.
Boston, Mass.

WEDNESDAY

12:30 p.m.—Lunchean, E.E.N.T.
3:45 p.m.—E.E.N.T. (Ophthalmalagy)
8:00 p.m.—Joint Specialty meeting—E.E.N.T.

D. W. EASTWOOD, M.D.
Charlottesville, Va.

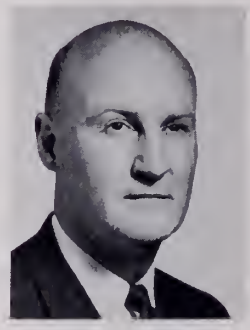
WEDNESDAY

12:30 p.m.—Lunchean, Anesthesia
2:00 p.m.—Anesthesia
3:45 p.m.—Panel, Anesthesia

Evan Fredericksan, M.D.
Kansas City, Kan.

WEDNESDAY

12:30 p.m.—Lunchean, Anesthesia
2:30 p.m.—Anesthesia
3:45 p.m.—Panel, Anesthesia



J. A. HILGER, M.D.
St. Paul, Minn.

WEDNESDAY

12:30 p.m.—Luncheon, E.E.N.T.
2:00 p.m.—E.E.N.T.
5:00 p.m.—Jaint Specialty Meeting, E.E.N.T.

H. B. HALL, M.D.
Minneapolis, Minn.

WEDNESDAY

9:30 a.m.—Fractures
11:15 a.m.—Panel, Fractures
Evening Speaker at Wiscansin Orthapedic Society Dinner Meeting

S. H. GARDINER, M.D.
Indianapalis, Ind.

MONDAY

11:15 a.m.—Panel, OB-Gyn
12:30 p.m.—Lunchean, OB-Gyn
2:00 p.m.—OB-Gyn

William Beaumont Memorial Lecture

Sponsored by the CES Foundation
of the State Medical Society

GUEST LECTURER

David Yi-Yung Hsia, M.D.

Professor of Pediatrics, Northwestern
University School of Medicine, Chicago, Ill.

TUESDAY—2:00 P.M.
Plankinton Hall—Milwaukee Auditorium

"Inborn Errors of Metabolism"

D. Y. HSIA, M.D.
Chicago, Ill.

TUESDAY

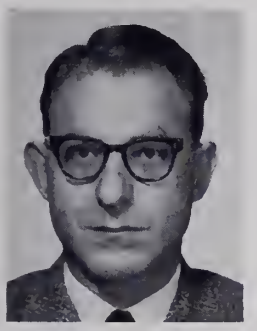
11:30 a.m.—Panel, Medical Genetics
12:30 p.m.—Luncheon, Pathology
2:00 p.m.—Medical Genetics
3:45 p.m.—Medical Genetics

ISADORE LAMPE, M.D.
Ann Arbor, Mich.

WEDNESDAY

3:45 p.m.—Radiology

Evening Speaker at Wisconsin Radiological Society Dinner Meeting



A. G. MOTULSKY, M.D.
Seattle, Wash.

12:30 p.m.—Luncheon, Medical Genetics
2:30 p.m.—Medical Genetics
3:45 p.m.—Medical Genetics

B. C. SCHIELE, M.D.
Minneapolis, Minn.

TUESDAY

12:30 p.m.—Luncheon, Psychiatry
2:00 p.m.—Psychiatry

WEDNESDAY

12:30 p.m.—Luncheon, Orthopedics

R. W. STANDER, M.D.
Indianapolis, Inc.

MONDAY

9:30 a.m.—OB-Gyn
11:15 a.m.—Panel, OB-Gyn
12:30 p.m.—Luncheon, OB-Gyn

R. T. TIDRICK, M.D.
Iowa City, Ia.

WEDNESDAY

3:45 p.m.—Surgery

Evening Speaker at Wisconsin Surgical Society Dinner Meeting

HOSPITALITY CENTER AND MEDICAL ART SALON

Special Annual Meeting Feature Sponsored by the Woman's Auxiliary

Be sure to visit the Auxiliary Hospitality Center (Milwaukee Auditorium, May 11–12–13), have a cup of coffee, and review the various watercolor and oil paintings and sculptures of Wisconsin MDs and their wives.

BE SURE TO VOTE FOR THE PICTURE AND SCULPTURE WHICH APPEAL TO YOU MOST!

RESERVATION FORMS FOR

Noon Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities and taxes.

MONDAY, MAY 11 (See pages 173 and 174 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. BORGES: IRONIC RETICULOCYTE
2. BOLES: SURGICAL EMERGENCIES IN NEWBORN
3. GARDINER: OBSTETRICIAN AND PREMATURITY
4. STANDER: ANTENATAL PREDICTION OF ERYTHROBLASTOSIS FETALIS

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice. _____

TUESDAY, MAY 12 (See page 175 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. MEYER: RECENT ADVANCES IN THERAPY
1. MOTULSKY: CLINICAL APPLICATIONS OF MEDICAL GENETICS
3. HSIA: JAUNDICE IN NEWBORN INFANT
4. SCHIELE: MAINTENANCE THERAPY WITH PSYCHOTROPIC DRUGS
5. HICKEY: RESUME OF CONTROVERSIAL ASPECTS OF BREAST SURGERY

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice. _____

WEDNESDAY, MAY 13 (See pages 178 and 179 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. EASTWOOD: DEVELOPMENT OF ATELECTASIS DURING ANESTHESIA
2. FREDERICKSON: CLINICAL HYPOTENSION WITH HALOTHANE
3. BIRMINGHAM: USE AND MISUSE OF PATCH TEST IN DIAGNOSIS OF OCCUPATIONAL SKIN DISEASE
4. HALL: FLEXION AND EXTENSION INJURIES TO NECK FOLLOWING REAR-END AUTO COLLISION
5. HARDMAN: NEW CONCEPTS IN DRUG THERAPY OF ANGINA PECTORIS
6. CROW: MEDICAL GENETICS AS PUBLIC HEALTH PROBLEM
7. BUCHTEL: RADIOLOGIC ASPECTS OF ACUTE GASTROINTESTINAL HEMORRHAGE
8. E.E.N.T. LUNCHEON

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice. _____

ANNUAL DINNER, Tues., May 12

DANCING
SHORT SPEECHES—COCKTAILS

$7.00 PER PERSON (Including Gratuities and Taxes)

Number Luncheon Tickets ($2.50 each) . . . . . _____ for $_____

Number Annual Dinner Tickets ($7.00 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____

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WOMAN'S AUXILIARY

1964 Annual Convention—Program Highlights

MRS. W. D. JAMES
Oconomowoc
State President

MRS. J. J. SATORY
LoCrosse
President-Elect

MRS. C. RODNEY STOLTZ
Watertown, South Dakota
President
Woman's Auxiliary to the
American Medical
Association

MRS. HAVEN SMITH
Chapell, Nebraska
National Chairman
American
Farm Bureau Women

Monday, May 11

P.M.

3:00—REGISTRATION

Main Lobby, Hotel Schroeder

5:30—SOCIAL HOUR

Lobby of Club Rooms, Hotel Schroeder

6:30—BOARD OF DIRECTORS' DINNER AND MEETING

Club Rooms, Hotel Schroeder

Those who attend: State Officers, Directors and Chairmen, County Presidents and Presidents-elect, Past State Presidents, Post National President and Honored Guests

Tuesday, May 12

A.M.

8:30—REGISTRATION

Main Lobby, Hotel Schroeder

9:00—CONTINENTAL BREAKFAST

Loraine Room, Hotel Schroeder

9:30—FIRST BUSINESS SESSION

Loraine Room, Hotel Schroeder

P.M.

12:30—LUNCHEON honoring County Auxiliary Presidents

Milano Room, Milwaukee Athletic Club

MUSICAL PROGRAM, Mrs. Richard Graves, Campbellsport, Member of the Woman's Auxiliary to the Fond du Lac County Medical Society

WE'RE ALL IN THIS TOGETHER, Mrs. Haven Smith, Chapell, Nebraska, National Chairman, American Farm Bureau Women

(Guest Privileges)

MEETING OF COUNTY AUXILIARY PRESIDENTS AND PRESIDENTS-ELECT with Mrs. C. Rodney Stoltz, Watertown, South Dakota, President, Woman's Auxiliary to the American Medical Association

6:30—RECEPTION OF THE PRESIDENT OF THE STATE MEDICAL SOCIETY OF WISCONSIN

East Room, Hotel Schroeder (fifth floor)

7:15—ANNUAL DINNER OF THE STATE MEDICAL SOCIETY

Crystal Ballroom, Hotel Schroeder (fifth floor)

Wednesday, May 13

A.M.

8:30—REGISTRATION

Main Lobby, Hotel Schroeder

9:00—CONTINENTAL BREAKFAST

Loraine Room, Hotel Schroeder

9:30—SECOND BUSINESS SESSION

Loraine Room, Hotel Schroeder

MEMORIAL SERVICE
ELECTION OF OFFICERS
NEW BUSINESS

P.M.

12:30—LUNCHEON honoring Mrs. C. Rodney Stoltz, Watertown, South Dakota, President, Woman's Auxiliary to the American Medical Association

Stouffer's—Top of the Marine

AT THE PIANO, Bob Nolan, Kenosha

INSTALLATION OF OFFICERS

POWER UNLIMITED, Mrs. C. Rodney Stoltz

(Guest Privileges)

POST-CONVENTION BOARD MEETING

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available as the new individually-capped unit, boxes of 5, or in cartons of 25

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*Donnelly, J. A.M.A. Arch. Environmental Health 6:697 June, 1963

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The State Medical Society of Wisconsin

ORGANIZED 1841

W. J. EGAN, Milwaukee, President
W. P. CURRAN, Antigo, President-Elect
R. E. CALLAN, Milwaukee, Speaker
H. W. CAREY, Lancaster, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

J. C. FOX, La Crosse, Chairman
J. M. BELL, Marinette, Vice-Chairman

Term Expires 1966

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1965

Third District:
M. D. Davis.....Milton

Term Expires 1964

E. J. Nordby.....Madison

Term Expires 1966

C. W. Stoops.....Madison

Term Expires 1964

Fourth District:
E. M. Dessloch.....Prairie du Chien

Term Expires 1964

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
H. J. Kief.....Fond du Lac

Term Expires 1965

George Nadeau.....Green Bay

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

Eighth District:
J. M. Bell.....Marinette
(Vice-chairman)

Ninth District:
R. W. Mason.....Marshfield

Tenth District:
R. C. Frank.....Eau Claire

Term Expires 1966

Eleventh District:
V. E. Ekblad.....Superior

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1964

D. M. Willson.....Milwaukee

Term Expires 1965

S. L. Chojnacki.....Milwaukee
S. W. Hollenbeck.....Milwaukee

Thirteenth District:
Marvin Wright.....Rhinelander

Term Expires 1964

N. A. Hill.....Madison
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

John M. Bell, Marinette, 1964
E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1965
A. A. Quisling, Madison, 1965

Alternates

J. C. Fox, La Crosse, 1964
C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1965
W. B. Hildebrand, Menasha, 1965

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	L. W. Moody Bayfield	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	H. O. Jirsa Cumberland	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	L. H. Edelblute 744 S. Webster Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	John A. Knauf Stockbridge	
Chippewa	Charles A. Kemper 727 Maple, Chippewa Falls	James L. Windeck 600 Bay St., Chippewa Falls	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	Palmer R. Kundert 110 E. Main St., Madison	Gordon Davenport, Jr. 110 E. Main, Madison	Second Tuesday**
Dodge	Norman Erickson 302 N. Spring St., Beaver Dam	N. H. Schulz 317 E. Lake St., Horicon	Last Thursday*
Door–Kewaunee	W. S. Hobson 25 S. Madison, Sturgeon Bay	David Papendick 801 Fourth St., Algoma	
Douglas	Thomas J. Doyle 1507 Tower Ave., Superior	Oscar Farias Hawthorne	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	Harold Kief 104 So. Main St. Fond du Lac	W. G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	Carol E. Mueller Boscobel	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	John M. Irvin 2101 6th St., Monroe	Frank C. Stiles 921 16th Ave., Monroe	
Green Lake–Waushara	Russell C. Daroy Wautoma	Roy Hong Wild Rose	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	E. J. Hohler Mineral Point	H. P. Breier Montfort	First Thursday following first Monday
Jefferson	J. J. Harris 311 North Main, Jefferson	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	C. A. Sattler 6401 Sheridan Rd., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	Frederick H. Wolf 419 Main St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	L. J. Unterholzner Box 115, Blanchardville	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	Earl J. Roth 606 Superior, Antigo	First Monday
Lincoln	William Braun 412 W. Main St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	Charles E. Wall 904 South 8th St. Manitowoc	G. H. Stannard, Jr. Holy Family Hospital Manitowoc	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	Charles Koepp 516 Houston St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Robert S. Haukohl 620 N. 19th St., Milwaukee	Donald P. Babbitt 2701 E. Beverly Rd., Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	Michael Barton 907 Main St., Oconto	
Oneida–Vilas	George F. Pratt Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	Jack G. Anderson 424 Longview Ave. Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday* Elks Club
Ozaukee	Kenneth F. Pelant 1240 13th Ave., Grafton	Allen Misch 204 N. Washington St., Cedarburg	
Pierce–St. Croix	Ernest Drury New Richmond	P. H. Gutzler River Falls	Third Tuesday
Polk	Lloyd Olson St. Croix Falls	Paul Simenstad Osceola	Third Thursday 7:00 p.m.
Portage	R. H. Slater 401 Main St., Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	Frank J. Scheible 632 High St., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Ceraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	George Parke, Jr. 323 So. Central Ave., Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	E. W. Reinardy 2020 Milw. Ave., Janesville	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	I. A. Calarynk Plain	Gibbs W. Zauft 590 4th St., Prairie du Sac	Second Tuesday*
Shawano	H. F. Laufenburg Shawano	A. J. Sebesta 126½ S. Main St., Shawano	Third Wednesday
Sheboygan	Donald M. Rowe Kohler	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Albert Daniells 903 Filmore St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Joseph Syty Viroqua	C. A. Ender 120 W. Court St., Viroqua	Last Wednesday
Walworth	Henry F. Bischof 845 Main St., Lake Geneva	Rocco S. Calgano 610 Walworth, Delavan	Second Thursday*
Washington	James Albrecht 118 E. Main St., Jackson	W. E. Scheunemann 626 Cedar St., West Bend	Fourth Thursday
Waukesha	Robert Monk 217 Wis. Bldg., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	Kenneth L. Haman Waupaca	Lloyd P. Maasch Weyauwega	
Winnebago	R. V. Kuhn 219 West 9th St., Oshkosh	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
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CSO-1054

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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Journal
Established 1903
Annual Subscription ---- $6.00
Single Copy ---- 1.00
Previous Years' ---- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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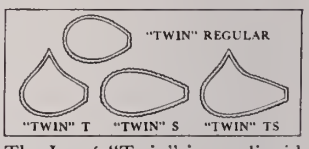

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GASTROCAMERA:

University of Wisconsin First in Country to Have New Diagnostic Device

■ THE UNIVERSITY of Wisconsin Medical School, Madison, is the first location in this country to have a new device for diagnosing gastric ailments. It is a Japanese-developed gastrocamera which takes color pictures of the interior of the stomach.

The camera is operated at Wisconsin by Dr. John Morrissey, assistant professor of medicine; Dr. Giuseppe Perna, National Institutes of Health research fellow, and Dr. Toshio Honda, visiting assistant professor of medicine.

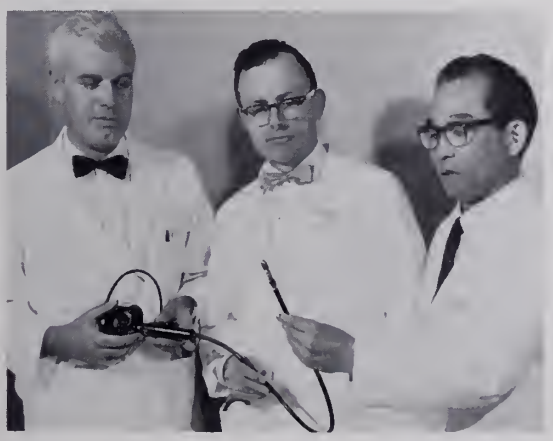
Wisconsin is also the first gastrocamera training center in the United States and will be the first center to be approved by the Japanese Endoscopic Society.

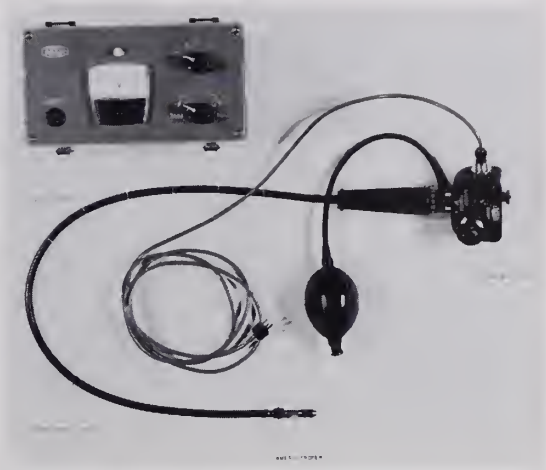
According to Doctor Morrissey, the gastrocamera is used in diagnosis along with the gastroscope and the fiberscope. But Doctor Morrissey said that the advantage of the gastrocamera is that it takes less time to operate and is much easier on the patient than a gastroscope. Also, a permanent record is obtained which can be shown to other physicians.

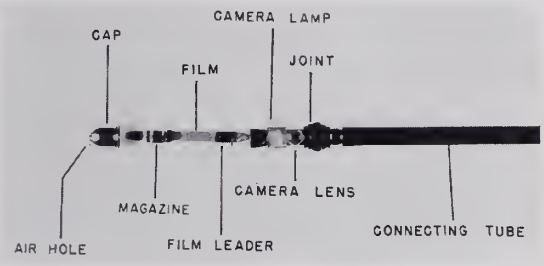
Another major advantage of the gastrocamera over the fiberscope and gastroscope is the very wide-angle view of the lens which permits an 80-degree field to be photographed. This permits gastric lesions to be seen in relation to landmarks within the stomach.

Operation of the camera is a relatively easy matter. The camera unit is very small and its connecting tube is flexible, covered with vinyl, and as thin as 8.5 mm. It is easy to swallow and unlike the conventional endoscope, gives little pain to the patient.

UNIVERSITY OF WISCONSIN physicians who operate the gastrocamera are, left to right: Drs. Giuseppe Perna, National Institutes of Health research fellow; John Morrissey, assistant professor of medicine; and Toshio Honda, visiting assistant professor of medicine.







The position of the camera in the stomach and the distention of the stomach is readily determined by observing the flash through the abdominal wall.

The camera can take 32 pictures. The film used—the size is 5 mm x 300 mm long—is Anscochrome with an ASA rating of 32.

The camera has three main parts: the camera, the connecting tube, and a control unit. The camera is located at the tip of the connecting tube. It is a small metal tube containing a lamp and a lens (F 17, f=3.6 mm). The cap at the head of the tube is removed to insert the film cassette.

The connecting tube links the camera with the control unit. The tube contains a film-winding string and a string to control camera-tip movement. The surface of the tube is marked at regular intervals to indicate depth.

The control unit allows the operator to advance the film, rewind the film, press the flash button, and direct the camera tip upward or downward.

Doctor Morrissey said that in using the camera to diagnose gastric ulcers, it is possible to visualize between 70 and 80 per cent. In Japan, where wider experience has been gained in the camera's use, the average rate of diagnosis for gastric ulcers runs between 80 and 85 per cent. Although in all studies a somewhat lower percentage of gastric ulcer diagnoses have been made by x-ray, the gastrocamera

does not replace the x-ray as the first study to be done in evaluating a patient.

Doctor Morrissey said, "The camera is definitely superior to the gastroscope and the fiberscope for the purpose of finding new lesions in the stomach."

The gastrocamera was developed by Dr. T. Uji, an engineer employed by the Olympus Optical Company of Japan. The first clinical trials were made at Tokyo Branch Hospital under supervision of Professor Hayashida. The subsequent development of the technique has been due largely to the efforts of Professor S. Tasaka and his associates at Tokyo University.

There are now approximately 6,500 to 7,000 gastrocameras in use in the world, almost all of them in Japan.

The first camera was brought to the University of Wisconsin by Dr. Yoshio Hara, who served as an intern here in the mid 1950's. Upon completion of his training here, he returned to Niigata University where he learned to use the camera.

Then in October of 1962, Doctor Hara returned to Wisconsin as a fellow in Clinical Oncology and brought one of the gastrocameras with him. While he was here, he taught Doctors Morrissey and Perna how to use it.

In late 1963, Dr. Toshio Honda came to Wisconsin and has been responsible for greatly improving the quality of gastrocamera photography in this country. Doctor Honda, a former student of Doctor Tasaka, is assistant professor of medicine at Nihon University, and a counsellor of the Japanese Endoscopic Society.

Use of the camera in the U.S. is growing. In addition to those at the UW, Dr. James R. Hoon of Sheboygan has recently been trained in its use. And this month, UW-trained doctors will begin using gastrocameras in Seattle, St. Louis, and Minneapolis.

MOUNT SINAI X-RAY SCHOOL GIVEN SPECIAL RECOMMENDATION

The Mount Sinai Hospital School of X-Ray Technology has been honored by a special commendation from the American College of Radiology and the Council on Medical Education of the American Medical Association.

The school was recently surveyed by a team representing the American College of Radiology and the American Society of X-Ray Technicians. The results inspired the following statement in a letter addressed to Dr. Morris Moel, director of the Mount Sinai department of radiology from the American College of Radiology.

"This school could easily serve as a model for other schools in our state, and has my wholehearted endorsement and unqualified approval. It probably deserves a special commendation."

The surveyors acted as a fact-finding group and the data collected was studied by a review team which was extremely complimentary about the great interest taken in the program by Doctor Moel and Miss Marion Feliner, head technician. Special mention was made of the excellent and meaningful records kept on each student, and the committee recommended unqualified approval of the Mount Sinai school, as did the Medical Education Council of the American Medical Association.

Established 17 years ago as a one-year school and changing to a two-year curriculum in 1957, the Mount Sinai X-Ray Technology school receives many applications and accepts four students each year over a two-year period. Doctor Moel, Dr. Lloyd Mark, and Miss Feliner are instructors in the school. The graduating students receive certificates qualifying them for the examination given by the American Registry of Radiologic Technologists. Students who pass the examination then become registered technicians.

GUIDE FOR AN OCCUPATIONAL HEALTH PROGRAM FOR HOSPITAL EMPLOYEES NOW AVAILABLE

"A General Guide for an Occupational Health Program for Hospital Employees" is now available from the State Board of Health. The publication provides some guiding principles and recommendations to assist individuals concerned with employee health programs in hospitals. It was developed by a joint committee representing the State Medical Society, State Board of Health, Wisconsin Hospital Association, and Wisconsin Nurses Association. A special effort was made in developing the guide to make it useful for both large and small hospitals.

Single copies are available free of charge from: Occupational Health Division, Wisconsin State Board of Health, Madison, Wisconsin 53702.

■ SUCH DIVERSE GROUPS of people as state officials, officers of organizations allied to medicine, voluntary health organizations, city boards of health, county agents, county home agents, homemaker clubs, to list a few, were all represented at the second Wisconsin Conference on Health Fads and Fallacies, held April 16, 17, and 18, at the YMCA Community Center in Port Edwards. Total attendance exceeded 500, with Friday's attendance approaching the maximum which could be accommodated.

Assistance in presenting the conference, sponsored by the State Medical Society, under the direction of its Commission on Public Policy, was received from the American Medical Association, State Board of Medical Examiners, Attorney General's Office, Wisconsin Pharmaceutical Association, Wisconsin Division of the American Cancer Society, Wisconsin Chapter of the Arthritis and Rheumatism Foundation, the Wisconsin Dietetic Association, and the Federal Food and Drug Administration. A special preview of films and exhibits was held on Thursday, April 16, and the formal program on Friday and Saturday, April 17 and 18.

LIEUTENANT GOVERNOR Jack Olson, left, dropped in on Saturday. Here, he's getting a lesson in running the fake medical machine, the microdynometer from Oliver Field, center, director of the Bureau of Investigation for the American Medical Association and Dr. C. F. Broderick, right, Wisconsin Dells, conference chairman. Doctor Broderick also moderated the Friday session and delivered an address on Saturday titled "Who Is Your Doctor?" which dealt with the borderline health practitioners who treat the sick.

HEALTH FADS AND FALLACIES

CONFERENCE HIGHLIGHTS

APRIL 16–17–18

A MAN WHO WAS BEDRIDDEN with arthritis for seven and a half years, Jerry Walsh, left, regional director of the Arthritis and Rheumatism Foundation at New York, and who received the Handicapped American of the Year award this year, said that the "doorbell doctors" who promise quick cures bring anguish and suffering to the country's 12 million arthritic patients, at a cost of $250 million per year. He is shown with Dr. Morris Fishbein, right, editor of MEDICAL WORLD NEWS, who, in a fast-paced talk, traced the history of his personal fight against charlatans in medicine, pointing out that he had been sued 21 times for a total of $40 million by fakes he had exposed, but he had never lost a case.

It is a tribute to the purpose of the conference and the leadership of Wisconsin physicians that so many nationally prominent speakers agreed to take part in the program. Friday's program endeavored to "state the problem," with three Wisconsin speakers joining with six from out-of-state to discuss fads and fallacies in fields such as cancer, arthritis, nutrition, and cosmetics. On Saturday three Wisconsin speakers and four national authorities outlined present efforts to curb quackery and offered suggestions on other possible actions in Wisconsin.

In the words of one of the national speakers, "Wisconsin is a leader in this fight against quackery and I personally know of four other states which have patterned their state conferences on quackery after your Wisconsin programs."

The effect of the conference continues to be evident with schools asking for scheduling of films for student assemblies, invitations received for physicians to speak before various groups on "quackery," materials being provided for development of programs for 40 women's clubs, larger paper mills in the area asking for materials for employee distribution, and the University of Wisconsin Extension Service asking for information on movies and exhibits for use in its programs.

In a final evaluation, the 500-plus persons who attended the conference constitute only a partial

number of those who will eventually be affected and profit by it. Many attendees represented organizations to which they will report in the future, making aware an even greater body of persons to the dangers and fallacies of quackery medicine.

ATTENDANCE AT THE CONFERENCE totoled 523—195 on Thursdoy, 207 on Friday, ond 121 on Saturdoy. Dr. W. J. Egon, president of the Stote Medicol Society, Milwaukee; and Dr. W. P. Curran, president-elect, Antigo, gave the welcoming addresses.

COURTESY LUNCHEONS ond coffee breoks were held during the conference which wos open to the public ond required no registration fee olthough odvonce registration was recommended.

"HAVEN FOR HUCKSTERS" wos discussed by Korl Kaufman, Ph.D., left below, deon of the College of Phormocy, Butler University, Indionopolis, Ind.; and Dr. Thomos Brannick, right below, of the Section of Psychiatry, Mayo Clinic, Rochester, Minn., presented "A Psychiotrist's View" during the Fridoy session. Other speakers that day included Dr. Herman Heise, Milwoukee, member of the AMA's Committee on Medicolegol Problems, who presented the topic "Nutrition Nonsense;" Miss Lindo Allen, administrotive ossociote of the AMA's Committee on Cutoneous Heolth ond Cosmetics, who spoke on "Ccsmetic Chicanery," pointing out thot while women moy be susceptible to the fantastic claims of some cosmetics, men ore just as vulneroble when it comes to hair restoring preparations; and Froncis Wilcox, Eau Cloire attorney and choirmon of the Board of Directors of the Americon Cancer Society, who presented the subject "Unproven Concer Cures."

SATURDAY'S SESSION featured representatives from stote and federol government, outlining the investigative and enforcement powers of the Federol Food ond Drug Administrotion, the ottorney generol's office ond the Boord of Medicol Examiners. Eugene Warren, left, legal counsel of the Arkonsas Medical Society, Little Rock, spoke on limited licentiates; Worren Resh, center, ossistant attorney generol of the Stote of Wisconsin, Madison, outlined the role played by that office in protecting consumers and improving the professions; ond Dr. T. W. Tormey, Jr., right, executive secretary of the Wisconsin Stote Boord of Medicol Exominers, Madison, spoke on the role played by the board in investigating froudulent heolth schemes in the stote.

"UNPROVEN CANCER 'CURES'" were discussed ot the Friday session by Dr. Goil Williams, Morshfield, ond Dr. August Jurishica, Milwoukee.

CHARLES JAMES, left, ossistant ottorney generol of the Stote of California, Sacramento, and Worren Resh, right, assistont ottorney general of the State of Wisconsin, Modison, were porticipants in the Saturday session. Also porticipating in the Saturday session were Robert Kleckner, medical editor of the CHICAGO SUN–TIMES, Chicago, who outlined the role of the communicotions media; A. Horris Kenyon, director of the Minneopolis District of the FDA, Minneapolis, who spoke on the "FDA in Action;" ond Dr. W. W. Bauer, emeritus director of Heolth Education of the AMA, Chicogo, who closed the conference with an oddress on "Educotion—A Weopon Against Quockery." Dr. W. T. Russell, Sun Prairie, vice-choirman of the Society's Commission on Public Policy, wos moderator of the Saturdoy session.

COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

The Ashland–Bayfield–Iron County Medical Society met at the Marine Club in Ashland on March 26. The meeting was called to order by *Dr. L. W. Moody*, Bayfield, president. Mr. Glenn C. Waldschmidt, State Medical Society regional representative, showed a film on the King–Anderson bill, and a paper on "Chest Emergencies" was presented by Doctor Fuller of Duluth, Minn. The next meeting will be held in June.

BROWN

The Brown County Medical Society met on March 12 with fifty physicians attending. Cerebral palsy was discussed among the members. The Society decided to donate $50.00 to the American Red Cross, Green Bay Chapter, and $100.00 to the Green Bay Science Fair. Following the social hour and dinner, the A.M.A. movie "Hometown" was shown, followed by an address by *Dr. G. S. Kilkenny*, associate professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee, on "Moral Aspects of Gynecology."

DOUGLAS

The March meeting of the Douglas County Medical Society was held on March 4 at the Lakewood Room, Saratoga Cafe in Superior. The guest speaker, Dr. John Banovetz, of Minneapolis, Minn., spoke on Diagnosis and Treatment of Facial Injuries. His presentation was discussed by Dr. William Merrick, Duluth, Minn.

New members of the Society are *Dr. Robert Mann*, roentgenologist, St. Mary's and St. Joseph's Hospital, Superior; *Dr. John Knights*, roentgenologist, Superior Memorial Hospital; and *Dr. C. M. Scott*, who has been in general practice in Superior since July 1963.

On April 1, the Society met in joint session with the dentists and druggists of the City of Superior at Cronstrom's Supper Club. Following the dinner, which was served to 82 members and wives of the newly formed Interprofessional Council of Dentists, Doctors and Druggists, Glenn Waldschmidt, regional representative of the State Medical Society, was introduced and then showed a film entitled, "The Gift of Health."

FOND DU LAC

The February meeting of the Fond du Lac County Medical Society heard *Dr. Ben R. Lawton*, chief of surgery at Marshfield Clinic, Marshfield, speak on the management of chest injuries. The Society voted to give full support to the local Future Doctors of America organization. Society members also voted to contribute in memory of Dr. James Hanson, a former Fond du Lac physician who died recently in a skiing accident, to the William S. Middleton Memorial Library which is to be established in the University of Wisconsin Medical School.

GREEN LAKE–WAUSHARA

The Green Lake–Waushara County Medical Society met in Barnekow's Supper Club, Princeton, on March 26. The featured speaker was *Dr. M. J. Javid*, Madison, who spoke on "Care and Treatment of Injuries Involving the Head and Spinal Cord." *Dr. Steve R. Osicka*, who had practiced at Amherst for 13 years and who recently became associated with *Dr. L. J. Seward*, Berlin, transferred his membership from the Portage County Medical Society to the Green Lake–Waushara County Medical Society. The next meeting will be held May 21 in Green Lake.

KENOSHA

The Kenosha County Medical Society held its regular dinner meeting on April 2, at the Elks Club, Kenosha, it was reported by *Dr. Gene Armstrong*, Kenosha, secretary of the Society.

OZAUKEE

The Ozaukee County Medical Society was host to the members of the county bar association in Port Washington, February 27. Mr. Irving W. Zirbel, a Milwaukee attorney, spoke on professional service corporations.

SAUK

The Sauk County Medical Society met April 14 in Baraboo. The featured speaker was *Dr. Edgar Gordon*, Madison, who discussed "Recent Advances in Medicine."

SHEBOYGAN

The Sheboygan County Medical Society held a joint meeting with the Sheboygan Life Underwriters Association in Sheboygan on March 20.

WASHINGTON

The Washington County Medical Society at a recent meeting passed a resolution asking the Washington County Board and members of the Institutions Committee and trustees of the County Hospital and Home to give consideration to the possibility of constructing a new county home.

WAUKESHA

The 1964 officers of the Waukesha County Medical Society are: president, *Dr. Robert S. Monk*, and

---

Physicians whose names appear in italics are members of the State Medical Society.

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vice-president, *Dr. Thomas E. Dugan*, both of Waukesha; secretary, *Dr. Wilbur E. Rosenkranz*, Mukwonago; and treasurer, *Dr. Jerome R. Bischel*, Waukesha.

WINNEBAGO

Members of the Winnebago County Medical Society were guests in March at a meeting of the Winnebago County Dental Society in Menasha. They heard a talk by *Dr. R. P. Gingrass*, Milwaukee, oral and plastic surgeon, who spoke on "Surgical Conditions of Temporomandibular of the Joints."

The next meeting of the Society was held on April 9. The featured speaker was *Dr. Jack Teasley*, Milwaukee, who talked on "Flexor Tendon Injury and Repair—How, Where, When, Why."

ELEVENTH MEDICAL DISTRICT

Twenty-three members and guests of the Eleventh Medical District met at the Scottie Club, Ashland, for a dinner meeting on April 2. *Dr. Samuel Perlson*, Milwaukee, presented a paper on "Control of Hypertension in the Pregnant Patient." Mr. H. B. Maroney, State Medical Society staff representative, discussed the state legislative medical bills and elaborated on implementing of the Kerr–Mills Law this July. Mr. Pharis Horton discussed the national and/or federal bills being offered in the legislature.

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*The therapeutic value of anabolic agents depends on the ratio of anabolic potency to androgenic effect. This anabolic–androgenic activity ratio of Winstrol is greater than that of all the oral anabolic agents currently in use.

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SPECIALTY SOCIETY PROCEEDINGS

Rock County Surgical Society

At a recent meeting 17 surgeons became founding members of the Rock County Surgical Society. The membership includes the surgical specialties as well as general surgeons. The initial officers are Doctors *George Thomas*, Janesville, president; *George Woodington*, Beloit, president-elect; *John Tordoff*, Janesville, secretary; and *Juan Beltran*, Beloit, treasurer. The group plans to have four scientific meetings each year.

ICDDD Unit Meets

The Interprofessional Committee of Dentists, Doctors, and Druggists (ICDDD) met recently in Superior. After the dinner, a film entitled "The Gift of Health" was presented under the direction of Mr. Glenn Waldschmidt, regional representative of the State Medical Society. It was the first time the movie had been shown in the Superior area.

Wisconsin Thoracic Society

A Milwaukee physician was elected president of the Wisconsin Thoracic Society at the annual meeting of the group at the Coach House Motor Inn, Milwaukee, April 4. He is *Dr. Benjamin Narodick*. The two other officers of the society were reelected. They are *Dr. J. Richard Johnson*, Madison, vice-president; and *Dr. William W. Stead*, Wauwatosa, secretary-treasurer. Doctor Stead is medical director of Muirdale Sanatorium in Wauwatosa.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met March 17 at the University Club, Milwaukee. Dr. Maurice H. Seevers, professor and chairman, department of pharmacology, University of Michigan, Ann Arbor, spoke on "Narcotic and Drug Abuse Problems in the United States." The April 21 meeting featured Dr. Murray M. Copeland, University of Texas, M. D. Anderson Hospital and Tumor Institute, who addressed the Academy.

Wisconsin League for Nursing

The 12th annual meeting of the Wisconsin League for Nursing was held April 10 at the Coach House Motor Inn, Milwaukee. The business meeting in the morning was presided over by the president, Louise M. Schmitt, and a program on "Community Involvement for Nursing" was presided over by Florence R. Durkee, chairman of the committee on careers. After the noon luncheon, Doris Jones, president-elect of the Wisconsin League for Nursing, presided over the session on "Cooperation Among Health Disciplines."

Milwaukee Pediatrics Society

The Milwaukee Pediatrics Society met recently and heard Dr. Barton Childs, a professor of pediatrics at Johns Hopkins University Medical School, speak on the hereditary aspects of intelligence. Doctor Childs was in Wisconsin for two weeks as a visiting professor at Marquette University School of Medicine under the sponsorship of the school's department of pediatrics and the Edward A. Uhrig Foundation.

Milwaukee Gynecological Society

Dr. Michael Newton, chairman of the department of obstetrics and gynecology, University of Mississippi Medical Center, addressed the Milwaukee Gynecological Society, March 23, at its meeting at the University Club.

Milwaukee Surgical Society

Dr. Philip H. Seefeld, Milwaukee, has been installed as president of the Milwaukee Surgical Society. He succeeds *Dr. James Sullivan*, Milwaukee. *Dr. F. J. Stoddard*, Milwaukee, is the Society's new secretary–treasurer.

Wisconsin Anti-Tuberculosis Association

More than 500 persons from throughout Wisconsin attended the conference on tuberculosis eradication at the Coach House Motor Inn, Milwaukee, April 2–3, sponsored by the Wisconsin Anti-Tuberculosis Association (WATA).

Mrs. Konrad Testwuide, Jr., Sheboygan, took over as president of the Wisconsin Anti-Tuberculosis Association at the conclusion of the conference. Harry G. Marsh, Madison, was chosen president-elect. Elected vice-president was *Dr. James M. Wilkie*, medical director of Morningside Sanatorium, Madison. Two WATA officers were reelected. They are *Dr. Elwood W. Mason*, Milwaukee, secretary, and James P. Fitch, Milwaukee, treasurer.

Other members elected to the executive committee are *Dr. Henry Anderson*, medical director of River Pines Sanatorium, Stevens Point; Edward H. Borgelt, Milwaukee; T. A. Duckworth, Wausau; *Dr. Helen A. Dickie*, Madison; Dr. O. A. Sander, Milwaukee; *Dr. George C. Owen*, Milwaukee; and *Dr. Edward A. Bachhuber*, Milwaukee. One new member was elected to the WATA board of directors. He is Earl Munson, Cambridge, a member of the board of trustees of Lake View Sanatorium, Madison.

Physicians whose names appear in italics are members of the State Medical Society.

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For complete prescribing information, please see *PDR* or available literature.

Supplied: Bottles of 50 capsules.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Sturm Joins Clinic Staff

Dr. Rodney J. Sturm, Madison, recently joined the staff of the Davis and Duehr Eye Clinic, Madison. Doctor Sturm, a certified ophthalmologist, received his M.D. degree from the University of Wisconsin Medical School in 1956. He completed his ophthalmology residency at Wisconsin and Harvard Medical School, spent a year studying ophthalmology at the University of Miami, and served as ophthalmologist with the Air Force for three years.

U–W Emeritus Faculty Award to Dr. Stovall

Dr. William Davison Stovall, who has made such large contributions to medicine in Wisconsin in so many diverse ways, has been named the fifth recipient of the Emeritus Faculty Award of the Wisconsin Medical Alumni Association. Doctor Stovall, an emeritus professor of hygiene, will accept the award May 22 at Medical Alumni Day in Madison. The award is given to recognize his "qualities as an inspiring teacher and productive scholar; his dedication to the community; and his imagination as initiator of new programs in public health and welfare for the State of Wisconsin."

A man who has been as active as Doctor Stovall hardly needs any further identification—his list of titles, past and present, alone are staggering; collectively, they identify him as physician, administrator, professor, scientist, and politician.

R. E. Galasinski, M.D.

W. D. Stovall, M.D.

For nearly 44 years he was director of the State Laboratory of Hygiene. He was chairman of the Department of Preventive Medicine, professor of Hygiene, chairman of the State Board of Public Welfare, director of Clinical Pathology at Wisconsin General Hospital, acting superintendent of University Hospitals, chairman of the Medical Museum of Progress campaign, cofounder of the Wisconsin Division of the American Cancer Society, president of the State Medical Society of Wisconsin, and officer of many other professional and scientific organizations. Presently he is a special assistant to the dean of the University of Wisconsin Medical School.

Doctor Stovall's work has been recognized and honored previously. He has received the State Medical Society's Council Award of Honor, and the Annual Distinguished Service Award from the Wisconsin Division of the Cancer Society. In 1961 the State Medical Society dedicated an issue of the *Wisconsin Medical Journal* to him, and in 1962 an exhibit hall of the Museum of Medical Progress at Prairie du Chien was named the Stovall Hall of Health. He is currently president of the State Medical Society's CES Foundation which owns and operates the Museum.

The Medical Alumni Association's Emeritus Faculty Award this year is further recognition of his rare qualities and capabilities.

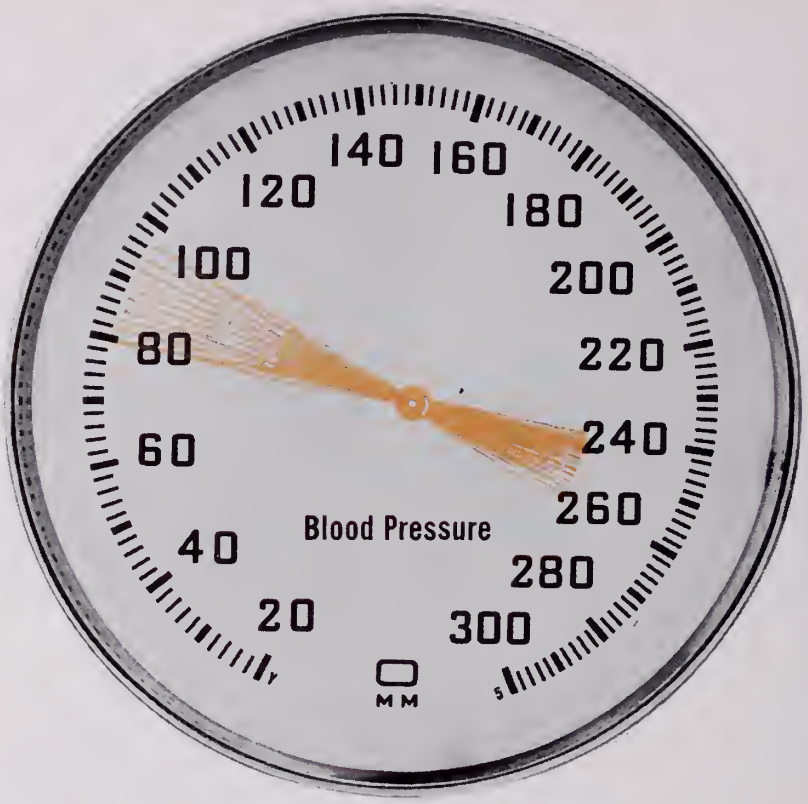
Dr. Galasinski Finds Religion a Help

Dr. Roman E. Galasinski, a Milwaukee physician and past president of the Medical Society of Milwaukee Chapter of the Catholic Physicians' Guild, says that he sometimes found that patients had greater tolerance to pain after receiving religious counsel, even though the patient may not be a practicing Christian. In a recent article in the MILWAUKEE JOURNAL, Doctor Galasinski explained that frequently everybody at some times finds that he needs a "sky hook," i.e. something supernatural, to hang onto when it seems that everything else fails. Perhaps miracles do not occur, but Doctor Galasinski says that there are "many things we cannot explain." And a minister or a priest at a bedside may sometimes be invaluable.

He elaborated in defining religion in broad terms of communication with the Creator, such communication being the source of faith from whence comes hope. He added that neither surgery nor drugs could sustain a life if the individual had lost the will to survive. Doctor Galasinski feels that a patient should be told if he is to survive or not, with the exception of the patient who is irrational or beyond communication or comprehension. Withholding the truth may destroy a physician's rapport with his patient, he believes.

Doctor Galasinski received a liberal arts degree and his M.D. from Marquette University. He began private practice after a year's residency at Milwaukee County Hospital and two years at Johnston Municipal Hospital. He served 42 months in the Navy Medical Corps in World War II, including two years at Pearl Harbor. He said he became cognizant of the role of military chaplains at this time.

Physicians whose names appear in italics are members of the State Medical Society.



15 mm. Hg. was the average diastolic drop reported following use of HYDROMOX Quinethazone in recent studies of patients with various hypertensive diseases, including essential hypertension and hypertension associated with arteriosclerotic heart disease, obesity, and renal disease.[1,2] The treatment period in one study was eight weeks[1] and in the other, twelve.[2] The lack of serious disturbances in serum electrolyte levels, particularly of potassium, was noteworthy. In fact, it was considered a sufficiently important factor to give the drug a preferential status.[2] A single daily dose of one to two 50 mg. tablets is usually sufficient.

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1. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962. 2. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

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Doctor Galasinski was a leader in the development of the new St. Luke's Hospital, Milwaukee, and served five years as chief of staff and four years as chief of surgery. He also aided in establishing St. Francis Hospital, Milwaukee. Doctor Galasinski described his work for the hospitals as his most important achievement.

Dr. Samp Speaks at Cancer Kickoff

"Additional Facts of Life for Green Countyites" was the topic *Dr. Robert J. Samp,* Madison, chose for the Cancer Drive Kickoff Dinner, held in Monroe, April 9. Doctor Samp, assistant professor of surgery, division of clinical oncology at the University of Wisconsin Medical Center, is medical director for the Wisconsin Division of the American Cancer Society and is a well-known lecturer. Being especially interested in the control of cancer via prevention, Doctor Samp has addressed more than 2,000 audiences in 400 cities in 41 states.

Dr. Smiley Speaks on Medical Problems

Dr. Glenn Smiley, Delavan, spoke recently to the Holy Name Society, St. Benedict Church, Walworth, on "Current Medical Problems and Recent Advances in Medicine."

Ambulance First Aid Classes

The first of a weekly series of first aid sessions were begun in March in Marshfield, under the direction of Marshfield Clinic physicians. The classes were held in anticipation of city-operated ambulance service which began in April, and is handled by the Marshfield Fire Department. Weekly speakers have been *Dr. D. M. Kinkel,* anesthesiologist; *Dr. J. W. Rupel,* obstetrician and gynecologist; *Dr. R. A. Pyka,* orthopedic surgeon; and *Dr. Francis Kruse, Jr.,* neurologist; all of the Marshfield Clinic.

Cancer Workers Hear Dr. Mirhoseini

Some 60 county volunteers gathered at the VFW clubhouse in Medford in March to lay plans for the American Cancer Society Crusade which was held in April and heard a talk on cancer by *Dr. Mahmood Mirhoseini,* Medford.

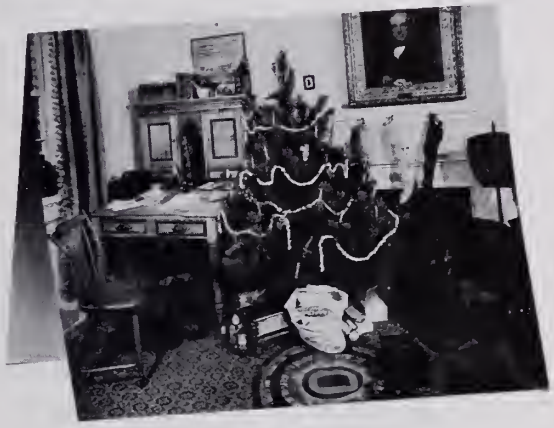
NIH Grants

Recent recipients of National Institutes of Health (NIH) grants at the University of Wisconsin are: Dr. L. J. Gosting, for arthritis; Dr. Eileen M. Hetherington, for mental health; *Dr. Matthew D. Davis* and Dr. J. W. Williams, both for arthritis.

Dr. Cantwell Cancer Speaker

Dr. R. C. Cantwell, Green Bay, was the guest speaker for the kickoff meeting of the Oconto County Unit of the American Cancer Society's Crusade in April.

A Unique Christmas Card



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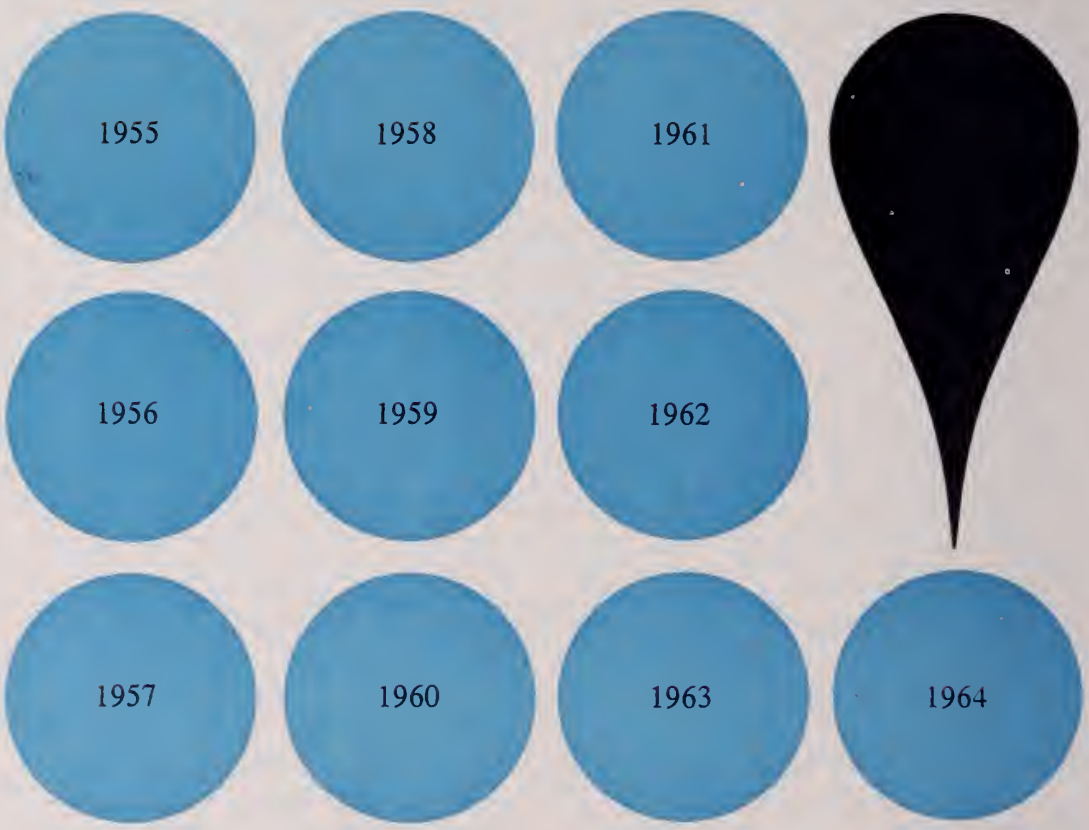

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Doctors Predict Well Cured Swiss Cheese

Shown selecting a wheel of 200 pounds of naturally cured Swiss cheese in the cooling room of the Monroe Cheese Corporation, Monroe, are *Drs. James R. Weir* and *Robert G. Zach*, both of Monroe. The Swiss cheese was featured at the Wisconsin hospitality room during the meeting of the American Academy of General Practice in Atlantic City, April 9–13. Doctors Weir and Zach diagnosed that the "heart" of the cheese contains "murmurs of goodness" which they then confirmed by biopsy. A short life was predicted once the American Academy of General Practice made an incision.

Dr. Schorr Tell of Venezuelan Conditions

A first hand view of terrorist activities marking the election campaigns in Venezuela was given Marshfield Kiwanians at their March meeting by *Dr. William F. Schorr*, Marshfield. Doctor Schorr, a dermatologist at the Marshfield Clinic, and his family spent seven months in Caracas where he studied tropical diseases at the government's Vargas Hospital. He displayed copies of Venezuelan newspapers with accounts and pictures of FALN violence and also showed slides depicting many facets of the Venezuelan life.

Dr. Rice Speaks on Heart Disease

Dr. Raymond L. Rice, Milwaukee, addressed members of the Shorewood Men's Club at their dinner meeting April 1. His topic was "Heart Disease and You." Doctor Rice, an internal medicine specialist and assistant clinical professor of medicine, Marquette University School of Medicine, appeared through Wisconsin Heart Association sponsorship. He is immediate past president of the Wisconsin Heart Association and a member of its speakers committee. He is senior attending physician at Milwaukee County Hospital and is on the consulting staffs of Trinity Hospital and Doctor's Hospital.

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Memories of "Hope" Recalled

—Photo courtesy of La Crosse Leader-Tribune

Dr. William Gallagher (standing left), La Crosse, and Eduardo Farga (standing center) met recently in La Crasse ta discuss their meeting in Sauth America abaut twa years aga. Forga, af Trujilla, Peru, was an emergency patient of Dactor Gallagher aboard the USS HOPE, the medical mercy ship statianed in Latin American waters at that time. Forga and his wife (seated center) were in Milwaukee an a business trip and "drapped in" at La Crosse. Dr. Ubalda Alvarez (standing right), La Crasse obstetrician and native af Calambia, S. A., alang with his wife (seated at right) escarted the Peruvians an a brief tour af the La Crosse area. Mrs. Gallagher is seated at left.

Dr. Copps Talks on Brain Damage

Dr. Stephen C. Copps, La Crosse, spoke recently to the Council for Exceptional Children in Hamilton School, La Crosse. He discussed brain damage in children, notably the primary symptoms—unpredictable behavior, hyperactivity, distractability, impulsiveness, irritability, and difficulties in abstract thinking.

Dr. Schroeder Vernon County Speaker

Dr. John M. Schroeder, Madison, assistant professor at the University of Wisconsin Medical School, addressed members of the Vernon County Unit of the American Cancer Society at their crusade kick-off meeting in April.

Dr. Welsch Honored for Polio Work

Dr. Raymond G. Welsch, Kenosha, was honored in March by the Kenosha Newspaper Guild Local 159 as its fifth recipient of the Walter T. Marlatt Page One Award. The award was given to Doctor Welsch in recognition of his outstanding service to the community in directing the highly successful Sabin oral polio vaccine program last year.

A graduate of St. Mary's College, Doctor Welsch received his M. D. from St. Louis University and came to Kenosha in 1953 after three years of residency at the Milwaukee County Children's Hospital. He served as chief-of-staff of St. Catherine's Hospital, Kenosha, in 1963, and currently is president-elect of the Kenosha County Medical Society.

Dr. Longe Reelected Chief

Dr. William G. Longe, Wauwatosa, has been reelected chief-of-staff for the West Allis Memorial Hospital. New officers chosen were *Dr. Gregory Inda,* Milwaukee, chief of medicine; *Dr. Edward D. Wilkinson,* West Allis, chief of general practice; *Dr. Ronald C. Johnson,* West Allis, chief of pediatrics; and *Dr. Harold J. Conlon,* Milwaukee, chief of in-house service. Reelected were *Dr. William W. Baird,* West Allis, vice-chief of staff; *Dr. Carl Zenz,* West Allis, secretary-treasurer; *Dr. Henry F. Twelmeyer,* Wauwatosa, chief of surgery; and *Dr. Carlton Wirthwein,* Milwaukee, chief of obstetrics and gynecology.

Dr. Smejkal Is Symposium Delegate

Dr. Walter F. Smejkal, Manitowoc, was a delegate of the A. M. A. to the Third International Symposium on Fleming's Lysozyme held in April in Milan, Italy.

LIONS CLUB SPONSORS EYE BANK

The Lions Club Foundation of Wisconsin has undertaken sponsorship of the Milwaukee Eye Bank and will hereafter be known as the Wisconsin Eye Bank. Affiliation will be retained with Marquette University Medical School. Future plans call for the establishment of branch eye banks in various cities throughout the state of Wisconsin.

Dr. Erwin E. Grossmann was renamed as Medical Director. Advisory Committee will consist of: Dr. Robert Lehner, Racine; Dr. John Berger, Madison; Dr. Clemens Kirchgeorg, Neenah; Dr. George Nadeau, Green Bay, and Dr. Karl Schmidt, La Crosse. Dr. John B. Hitz was named chairman of the State Advisory Committee.

For the present all procurement of eyes will be confined to the Milwaukee area. Eyes, however, are supplied to physicians in other Wisconsin cities. The eyes are removed shortly after death by residents in ophthalmology at the VA Hospital, Milwaukee, or the Milwaukee County General Hospital. The Wisconsin Eye Bank is located at the Milwaukee Blood Center, 763 North 18th Street, Milwaukee 3, Wisconsin.

Dr. Chase Speaks on Heart Disease

Dr. Jules Chase, Milwaukee, spoke on heart disease to members of Kingsley Methodist Church circle, Milwaukee, on April 13. Doctor Chase, internal medicine specialist and assistant clinical professor of medicine at Marquette University School of Medicine is a member of the Wisconsin Heart Association's Milwaukee speakers bureau which sponsored his appearance.

Dr. Shahrokh Discusses Deafness

Dr. Darius Shahrokh, otolaryngologist at Fond du Lac Clinic, gave a fully illustrated talk about conductive deafness and its treatment at the monthly staff meeting of Waupun Memorial Hospital, April 2. In his presentation, he reviewed otosclerosis, perforation of tympanic membrane and serous otitis media, stressing mainly their diagnosis and treatment.

Attend Meeting on Alcohol and Drugs

Dr. Arnold H. Barr, Port Washington, and *Dr. James Weygandt*, Sheboygan Falls, attended the subcommittee meeting on Alcohol and Drugs in New York City, March 13. The meeting was held in the office of Dr. George M. Wheatley, chairman of the Committee on Health, Medical Care, and Transportation of the Injured, which is part of the President's Committee for Traffic Safety. The chairman of the subcommittee on Alcohol and Drugs is Dr. Marvin A. Block of Buffalo, N. Y.

Dr. Howell Named Head of Staff

Dr. E. C. Howell, Fennimore, has been elected chief-of-staff for the coming year at Memorial Hospital, Lancaster. He succeeds *Dr. Glenn C. Hillery*, Lancaster. Dr. G. Burton Block, was reelected secretary-treasurer. Doctor Howell is a graduate of Marquette University School of Medicine and did his internship at Milwaukee County Hospital in 1911. Except for spending two years in the army during World War I, Doctor Howell has practiced medicine in Fennimore for over 50 years. He has been a member of the medical staff at Memorial Hospital since it was opened in September 1955.

Dr. Sullivan Speaks

Dr. John T. Sullivan, Jr., Milwaukee, addressed the Milwaukee County Association of Medical Record Librarians on April 17. He spoke on "Power Mower Injuries," as an attempt to make the public aware of the dangers and hazards of power mowers and emphasizing the rules of safety. Doctor Sullivan has done research on the subject at St. Joseph's Hospital, Milwaukee.

Dr. Duehr Attends Meeting

Dr. Peter A. Duehr, Madison, attended a meeting of the Association for Research in Ophthalmology at the Florida Medical Center, Gainesville, in March.

Dr. Donovan Receives Legion of Merit

Dr. William N. Donovan, Madison, retired colonel of the Army Medical Corps and now a physician on the University of Wisconsin student health staff received the Legion of Merit recently at a ceremony in Madison. The award cites Doctor Donovan for his service from 1959–1963 as deputy commander and later commanding officer of the 130th Station Hospital in Europe and as surgeon of the artillery and missile center and commanding officer of the Army Hospital, Ft. Sill, Okla.

Newborn Conference

The first of a series of conferences held on Care of the Newborn was held April 1, St. Francis Hospital, La Crosse. Shown at registration desk are (left to right): Ray T. Ragatz, Assistant Secretary, State Medical Society; Sister De Chanstal, St. Francis Hospital; Dr. James Wardlaw, State Board of Health; Dr. T. E. Bastan, Hillsboro; Miss Helen Callan, R. N., State Board of Health consultant; and Dr. W. N. Ottersan, Westby.

Dr. T. V. Geppert, Madison, is shown addressing the group at Care of Newborn Conference, La Crosse. The attendance was 121 nurses, physicians, and student nurses from St. Francis. Future conferences will be held in New Richmond, June 9; Superior, June 10; and Antigo, June 11. They have been planned cooperatively by the SMS Division on Maternal and Child Welfare of the Commission on State Departments and the State Board of Health. —Photos courtesy of La Crosse Leader–Tribune

Dr. Hankwitz Saves Youth By Heart Massage

Dr. Arthur W. Hankwitz, Milwaukee, is shown massaging the heart of Eugene Coblentz, Milwaukee, after an auto accident on March 21. The picture was made by the doctor's son, John.

Dr. Arthur W. Hankwitz, Milwaukee, recently saved the life of a young man whose heart and breathing had stopped due to a head blow suffered when his automobile rammed a telephone pole. The accident occurred Saturday night, March 21, in Milwaukee, near the Hankwitz' house where the doctor was watching television prior to hearing the crash. He rushed to the scene of the accident and found the youth lying on the ground, having been removed from the car by passersby. Doctor Hankwitz immediately applied external heart massage and after about five minutes, the youth's breathing and heart rhythm were restored.

Dr. Church Addresses Women

Dr. Ruth Church, medical director of the Waukesha County Health Department, discussed the "Challenge of Health" at a meeting of the history department of the Waukesha Women's Club held in March.

Dr. Skemp Honored

Dr. Fred C. Skemp, La Crosse, received Letters of Affiliation with the Institute of the Christian Brothers recently at a ceremony at St. Mary's College, Winona. Affiliation is the highest honor conferred on persons not members of the order. Doctor Skemp was cited for his "extraordinary kindness and generosity in caring for the Brothers." He is a graduate of St. Mary's College.

INTERDISCIPLINARY HAND CLINIC

Dr. Donald R. Schwartz, resident in orthopedic surgery at the University of Wisconsin Medical Center, is presenting a problem to the UW's newly organized Interdisciplinary Hand Clinic. The Clinic meets every Friday at 3 p. m. Visitors are welcome.

An Interdisciplinary Hand Clinic has been organized at the University of Wisconsin Medical Center, Madison.

The Clinic, which is attended by senior surgeons from the University of Wisconsin Medical School's sections of general surgery, orthopedic surgery, and plastic surgery, will direct attention to crippling deformities as arthritis, malformations, and particularly to hand trauma.

The Clinic meets every Friday afternoon at 3 p.m. in Room 526 of Wisconsin General Hospital, and visitors are welcome.

The Clinic is a joint program so that through combined experience benefits can be shared by the interested groups and the patients.

The first lecture under the Hand Clinic's auspices was given by Dr. Robert T. Tidrick, professor and head, Department of Surgery, State University of Iowa. He discussed "Vascular Malformations of the Extremities" on May 14 before the student body and faculty at Wisconsin General Hospital.

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Dr. Lanier Addresses AAUW

Dr. Patricia Lanier, Kewaunee, addressed the Kenosha chapter of the American Association of University Women (AAUW) at its meeting in March. She spoke on "The High Challenge of AAUW." Doctor Lanier received her A.B. and M.D. degrees from Washington University, St. Louis, Mo. She also studied at Leland Stanford University for two years on a research fellowship. Since 1950, she has been in private practice with her husband, *Dr. Andrew Lanier.*

Cancer Films Shown

Two films for women on the detection of cancer were shown at the Gethsemane Lutheran Church, Racine, recently. The films were shown under the auspices of the Racine Chapter of the American Red Cross and the Racine Cancer Society. *Dr. Albert C. Edwards,* Racine city health officer, was present to interpret the films and answer questions from the viewers.

Dr. Nebel Speaks on Hypnotism

Dr. John Nebel, Menasha, addressed the Menasha Homemakers in March. He discussed "The Art of Relaxing, or Everyday Hypnosis."

1966
125TH ANNIVERSARY YEAR
State Medical Society of Wisconsin

Plans are now being formulated for commemorating the 125th anniversary of the State Medical Society of Wisconsin in the year 1966, marking its origin as one of the oldest incorporated organizations in the State of Wisconsin. It is anticipated that final plans will be completed for presentation to the Council at its February–March meeting in 1965.

The Council has designated President Curran as chairman of a committee of physicians who will engage in developing plans for 1966. President-Elect Houghton will serve as vice-chairman. All living past presidents will serve on the committee. An organizational meeting of past presidents and staff coordinators was held April 19 in the Society offices.

All Divisions of the Society will be affected. Tentative proposals include special events at the Annual Meeting, a commemorative issue of the *Wisconsin Medical Journal,* events and affairs throughout the State.

Physicians are invited to offer suggestions and help in developing and carrying out the plans as they materialize.

Dr. Flynn Addresses Welcome Wagon

Dr. Richard T. Flynn, Jr., Milwaukee obstetrician and gynecologist, explained "Early Diagnosis of Pelvic Cancer," at the Welcome Wagon Newcomers Club, Milwaukee, March 12. To illustrate his talk, Doctor Flynn showed the film, "Time and Two Women," by the American Cancer Society.

Dr. Windsor Talks on Medicare

Dr. Richard Windsor, Sheboygan, discussed the King–Anderson bill at a recent public meeting sponsored by the Licensed Practical Nurses' Association of Sheboygan.

Dr. Dunn Named Medical Chief

Dr. Wilson S. Dunn, Madison, has been appointed medical director of the Dane County Guidance Center, a Red Feather agency. Doctor Dunn, who has been a staff psychiatrist at the center since November 1962, assumed his duties as medical director on April 1. He succeeds Dr. Leland K. Reeck, who resigned last August to take a position with the Palo Verde Clinic, Tucson, Ariz. Doctor Dunn received his medical training at the University of California, and was a resident at the University of Wisconsin Medical School. In addition to serving as staff psychiatrist at the center, he has engaged in private practice, been a consultant to the Dane County Public Assistance Department, and has been a clinical instructor at the University Medical School.

Dr. Freudenberg Talks to Kiwanis

Dr. John Freudenberg, Markesan, reviewed a newspaper article on the subject "Rights Violated in Commitments to Mental Hospitals" when he spoke recently to the Markesan Kiwanis Club.

Dr. Terry Leaves

Dr. R. E. Terry, Cuba City, has moved to Las Vegas, N. M., where he has become an administrator of a state hospital for patients with chronic and incurable diseases. He had been a physician in Cuba City for 37 years.

Dr. Unterholzner Featured

Dr. L. J. Unterholzner, Blanchardville, was featured recently in a MILWAUKEE JOURNAL article entitled "Memories Abound in Village Practice." Doctor Unterholzner has been Blanchardville's only physician since 1941, and has served the community a total of 33 years.

Dr. Nilles Speaks to PTA

Dr. John E. Nilles, Mishicot, spoke recently to a meeting of the PTA of the Mishicot Public School system on the subject of rabies, cause and prevention. He was assisted in his talk by Charles Horsens, state and federal veterinarian.

MEMBERSHIP REPORT AS OF APRIL 10, 1964

NEW MEMBERS

John B. Davis, 925 Mound Street, Madison.
Richard A. Eckberg, 501 McDill Avenue, Whiting, Stevens Point.
Frances E. Ehrlich, 1040 Sherman Avenue, Madison 3.
Charles H. Flint, P. O. Box 306, Minocqua.
Mary H. Frantz, Monroe Clinic, Monroe.
John R. Fuller, Monroe Clinic, Monroe.
John A. Gerdes, 212 James Street, Rothschild.
Sik Q. Jew, Monroe Clinic, Monroe.
John A. Knights, Superior Memorial Hospital, Superior.
Charles C. Lobeck, 1300 University Avenue, Madison.
Robert Mann, 515—3rd Avenue, East, Superior.
John G. Noble, 626—22nd Avenue, Monroe.
William B. Potos, 4602 South Packard Avenue, Cudahy.
Clarence M. Scott, 2209 East 5th Street, Superior.
Donald J. Taylor, 2710 Marshall Court, Madison 5.
Mario G. Tolentino, 425 East Wisconsin Avenue, Milwaukee.
Samuel W. Tonkens, 324 East Wisconsin Avenue, Milwaukee.
Harold B. Wagner, St. Catherine's Hospital, Kenosha.
James H. Weeks, 921—16th Avenue, Monroe.

CHANGES OF ADDRESS

George C. Arrambide, 332 Jefferson Avenue, Hartford.
H. W. Bardenwerper, 112 South Jefferson Street, Waterford.
Albert J. Baumann, 111 East Wisconsin Avenue, Milwaukee.
Robert G. Brault, Wauwatosa, to 1551 North Dousman, Green Bay.
Roland C. Brown, New York City, to 7447 West Beckett Avenue, Milwaukee.
John W. Bunke, Milwaukee, to 217 Wisconsin Avenue, Waukesha.
M. J. Chapman, Bethesda, Md., to 7 Beacon Terrace, Middletown, R. I.
David Cleveland, 1166 Sagebrush Road, Palm Springs, Calif.
John M. Coffey, Brookfield, to 9205 West Center, Milwaukee.
Quincy H. Danforth, 1703 Walnut Street, Oshkosh.
Otto F. Dierker, Bradenton, Fla., to P. O. Box 185, Youngstown, Ariz.
John Dooley, 105 West Silver Spring Drive, Milwaukee.
Carl G. Dunst, 1930 East North Avenue, Milwaukee.
Joseph F. Egan, La Crosse, to 145 West Main Street, Palmyra, N. Y.
Dean P. Epperson, 819 East Summit Avenue, Oconomowoc.
Diero G. Gasparri, Wood, to 1208 East Oklahoma Avenue, Milwaukee.
J. E. Gmeiner, 1260 Valley Road, Appleton.
Paul N. Gohdes, 225 Acewood Boulevard, Madison.
John P. Hartwick, Ft. McClellan, Ala., to 531 W24687 Sunset Drive, Waukesha.
H. J. Heath, San Diego, Calif., to 157 West North Street, Juneau.
Ann B. Henschel, Milwaukee, to P. O. Box 267, Wood.
Robert I. Hiller, Milwaukee, to % Schneider, 2930 North Sheridan, Chicago, Ill.
Donald E. Jacobi, Milwaukee, to 899 Pine Street, Apt. 1303, San Francisco, Calif.
Alfred Jerofke, Nekoosa, to V. A. Center, Wood.
Thomas A. Kegel, Milwaukee, to 542 Elm Spring Avenue, Wauwatosa.

SOCIETY RECORDS

Kenneth M. Klatt, Madison, to University Hospital, Baltimore 1, Md.
T. W. Klein, Marathon, Fla., to % Dr. John Erck, 10 Cheyenne Circle, Madison.
Milton G. Klumb, Milwaukee, to 2525 N. E. 8th Street, Fort Lauderdale, Fla.
Curtis C. Knight, Hollywood, Calif., to 333 West Washington Avenue, Madison.
H. H. Larson, 200 Seventh Avenue West, Ashland.
John W. Lowe, 430 McKinley Avenue, Eau Claire.
Isidro L. Maranan, 6890 North Beech Tree Drive, Milwaukee.
John J. Massart, 3016 North 52nd Street, Milwaukee 10.
John W. Maxwell, 2218 N. 3rd Street, Milwaukee.
R. E. McDonald, Milwaukee, to 2822 North Magnolia, Tucson, Ariz.
Frederick P. Nause, 1720 North 8th Street, Sheboygan.
Lyndle W. Peterson, Shawano, to 223 South Federal, Apt. 40, Dania, Fla.
Dennis F. Pierce, 5801 South 109th Street, Hales Corners.
William B. Rabenn, 7607 North Longview, Milwaukee.
Albert J. Randall, Kenosha, to P. O. Box 8499, Sarasota, Fla.
William R. Richards, 1260 Valley Road, Appleton.
Johanna E. Schlichting, 2121 N. 11th Street, Sheboygan.
Stephen Sipos, 6750 Sheridan Road, Kenosha.
Ralph F. Sortor, 10691 West Parnell Avenue, Hales Corners.
G. H. Stannard, 1425 Grinnell Lane, Manitowoc.
Robert E. Terry, Cuba City, to % New Mexico Hospital for Chronic Diseases, Las Vegas, N. M.
Ernest F. Wallner, 400 West Silver Spring Road, Milwaukee.
Ellison F. White, Harlingen, Tex., to Southern Wisconsin Colony, Union Grove.

REMOVED FROM MEMBERSHIP

Richard M. Block, Kenosha County, transferred to California.
Harry Chinchinian, Milwaukee County, transferred to Idaho.
David Cleveland, Milwaukee County, transferred to California.
Norman A. Evensen, Manitowoc County, removed per county secretary.
Eugene V. Grace, Green County, transferred to North Carolina.
Donald E. Gunderson, Milwaukee County, resigned.
Arvid G. Holm, Milwaukee County, resigned.
Wilhelm Klumper, Dane County, transferred to Iowa.
Carl T. Koenen, Milwaukee County, transferred to Idaho.
Robert G. Love, Grant County, removed per county secretary.
Sonja D. Monson, Dane County, resigned.
James A. Murphy, Milwaukee County, resigned.
Robert E. Oertley, Lafayette County, resigned.
Warne F. Ramsey, Eau Claire–Dunn–Pepin County.
Leland K. Reeck, Dane County, transferred to Arizona.
Gomer W. Roberts, Dane County, resigned.

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Contraindications: None reported.

Complete product information available in the product package, and to physicians upon request.

Dosage: Usual dosage is 1 or 2 tablets 4 times daily.

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*Donnelly, J: A.M.A. Arch. Environmental Health 6:697, June, 1963

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SOCIETY RECORDS *continued*

James R. Schmidt, Waukesha County, removed per county secretary.
Raymond M. Stark, Milwaukee County, resigned.
Howard M. Templeton, Marathon County, transferred to Illinois.
Virgil R. Vanstane, Dane County, transferred to West Virginia.

DEATHS

V. W. Rapp, nonmember, March 6, 1964.
Thurman E. Kendall, nonmember, March 11, 1964.
J. H. Fowler, nonmember, March 25, 1964.
Walter J. Clothier, Waukesha County, March 25, 1964.
Annette C. Washburne, Dane County, March 27, 1964.
Richard M. Rogers, nonmember, March 30, 1964.
John Louis Garvey, Milwaukee County, March 31, 1964.

NARCOTICS REGISTRATION DUE BEFORE JULY 1

Every physician who distributes, dispenses, gives away, or administers narcotic drugs to patients must register and pay a tax of $1.00 on or before July 1.

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MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph. D.
Clinical Psychologist

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Recent Wisconsin Licentiates

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, October 18, 1963.

Name	*School of Graduation*	*Year*	*City*
Acosta-Olmeda, Jose G.	Temple University	1959	Milwaukee
Allday, Robert L.	Tulane University	1962	Madison
Anderson, Rolf L.	Washington University	1962	Madison
Baker, Ralph K.	University of Wisconsin	1962	Madison
Beran, Frank V.	University of Iowa	1960	Madison
Blomgren, Stephen	University of Rochester	1962	Madison
Bostian, K. Eugene	University of North Carolina	1962	Madison
Brown, Richard J. C.	University of Wisconsin	1959	Milwaukee
Connolly, John F.	Marquette University	1961	Milwaukee
Crumpacker, Margaret	University of Wisconsin	1962	Wauwatosa
Daube, Jasper R.	University of Rochester	1962	Madison
Ellis, Ronald W.	Wayne State University	1960	Milwaukee
Faber, Denis D.	Marquette University	1961	Iowa City, Ia.
Fetherston, Thomas J.	Marquette University	1962	Milwaukee
Freeman, Lawrence	Marquette University	1962	Milwaukee
Gombas, Otto F.	University of Pecs	1952	Wauwatosa
Grose, Charles D.	Loyola University	1961	Glasgow AFB, Mont.
Guelcher, Robert T.	University of Buffalo	1960	Port Edwards
Haug, Norman Leo	University of Colorado	1962	Lakewood, Colo.
Hauser, Gary C.	University of Buffalo	1962	Madison
Hunter, Robert E.	Medical College of South Carolina	1959	Madison
Jacobs, Edmund B., Jr.	University of Cincinnati	1962	Madison
Johnson, John R.	Columbia University	1960	Madison
Kenny, John A.	Marquette University	1960	Milwaukee
Logemann, Ronald L.	University of Minnesota	1962	Shawano
Lubar, Howard S.	University of Illinois	1962	Madison
McAndrew, John B.	University of Nebraska	1959	Madison
McKenna, David H.	St. Louis University	1959	Madison
Olson, Neiland R.	Northwestern University	1962	Milwaukee
Pavlik, Kenneth K.	Creighton University	1959	Edgerton
Pearch, Luther W.	Albany Medical School	1955	Elkhorn
Peterson, William G.	Creighton University	1957	Madison
Pophal, Charles J.	Marquette University	1959	Milwaukee
Prickman, William	University of Minnesota	1959	Madison
Rank, Philip P.	University of Wisconsin	1960	Madison
Reichle, Robert I.	Ohio State University	1962	Clintonville
Reinert, John F.	University of Illinois	1946	La Crosse
Reul, George J., Jr.	Marquette University	1962	Wauwatosa
Richardson, Benson	Ohio State University	1960	West Allis
Richtarik, Marilynn	University of Arkansas	1959	Madison
Schorr, William F.	Marquette University	1957	Marshfield
Shore, Richard T.	Marquette University	1962	Wauwatosa
Sladky, James A.	Marquette University	1962	Racine
Stageman, John F.	University of Iowa	1960	Grantsburg
Swint, Margery J.	University of Michigan	1961	Milwaukee
Talebi, Ali A.	Istanbul University	1957	Skokie, Ill.
Thomas, Quentin M.	University of Colorado	1952	Madison
Trier, Jerry S.	University of Washington	1957	Madison
Ward, Richard H.	Ohio State University	1962	Madison
Waters, Raul F.	Wayne State University	1961	Milwaukee
Woloshin, Arthur A.	University of Illinois	1956	Highland Park, Ill.

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1964 **Wisconsin**

May 28: Mount Sinai Hospital May Day Program, hospital auditorium, Milwaukee.

June 5–7: Wisconsin State Medical Assistants Society, 10th Annual Meeting, Clayton House, Racine.

June 6: Scientific Meeting, Langlade County Medical Society, Langlade County Memorial Hospital, Antigo.

June 9: Care of Newborn Conference, Holy Family Hospital, New Richmond.

June 10: Care of Newborn Conference, New Memorial Hospital, Superior.

June 11: Care of Newborn Conference, Langlade County Memorial Hospital, Antigo.

June 13: Wisconsin Heart Association, Annual Meeting and nurses and closed chest resuscitation seminar, Wisconsin Center Building, Madison.

June 18–20: University of Wisconsin Postgraduate Program on Community Psychiatry, Wisconsin Center Building, Madison.

June 19–Aug. 3: Cardiovascular Disease Nursing Course, Marquette University School of Nursing, Milwaukee.

July 12–Aug. 2: Diabetes Association of Greater Chicago, summer camp for diabetic children, Holiday Home, Lake Geneva, Wis.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

Oct. 15–17: American College of Obstetricians and Gynecologists, District VI meeting, Milwaukee.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

1964 **Out-of-State**

June 1–5: American College of Physicians postgraduate course No. 17, "Recent Advances in Clinical Nutrition," Lemuel Shattuck Hospital, Boston, Mass.

June 1–5: Annual Meeting of the Medical Library Association, St. Francis Hotel, San Francisco, Calif.

June 8–12: American College of Physicians postgraduate course No. 18, "Recent Progress in Endocrinology," University of Washington School of Medicine, Seattle.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

June 21–25: 113th annual convention of the American Medical Association, San Francisco, Calif.

June 22–25: Catholic Hospital Association convention, New York City.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

June 26–July 1: Hawaii Medical Association seminar.

Aug. 2–14: Israel Medical Association, 6th World Assembly, Haifa, Jerusalem, and Tel-Aviv, Israel.

Aug. 3–7: University of Colorado School of Medicine, 7th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 24–27: American Hospital Association, Chicago.

Aug. 24–28: International Conference on Preventive Cardiology, University of Vermont, Burlington, Vt.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 17–19: Fifth National Cancer Conference, Philadelphia, Pa.

Sept. 21–25: Animal Care Panel, 15th annual meeting, Hilton Hotel, New York City.

Sept. 30–Oct. 2: Florida Diabetes Association, Seminar on diabetes and related endocrine disorders, Balmoral Hotel, Miami Beach, Fla.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 26–29: National Safety Congress, Chicago.

Nov. 3–7: American Society of Oral Surgeons, Forty-Sixth Annual Meeting, Las Vegas, Nev.

Nov. 13–16: 1964 annual convention of National Society for Crippled Children and Adults, Statler-Hilton Hotel, Detroit, Mich.

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

Florida Diabetes Association

The Florida Diabetes Association will conduct its annual Seminar on Diabetes and Related Endocrine Disorders, September 30, October 1 and 2, at the Balmoral Hotel, Miami Beach, Fla. There will be several out-of-state guest speakers and also speakers from the faculty of the School of Medicine, University of Miami.

Registration fee is $20.00 which should be sent to the president of the Association, George F. Schmitt, M.D., 30 S. E. 8th Street, Miami, Fla. Because of space, the number of registrants is limited to 125. Reservations for hotel rooms (which are $10.00 for singles and $12.00 for doubles daily) may be made directly with the hotel. The complete program may be obtained by sending a postcard to the president.

World Medical Assembly in Israel

The American Physicians Fellowship, an organization of 3,100 physicians who are nonresident fellows of the Israel Medical Association, announces that the Israel Medical Association will conduct its sixth World Assembly in Haifa, Jerusalem and Tel-Aviv, Israel from August 2 to August 14.

The American Physicians Fellowship is conducting a 24-day jet flight tour to Israel and three European capitals in conjunction with the World Assembly. Information and details about the Assembly or tour can be obtained by writing to the American Physicians Fellowship, 1622 Beacon Street, Brookline, Mass. 02146.

American College of Physicians

The American College of Physicians announces its postgraduate course no. 18, Recent Progress in Endocrinology, June 8–12. It will be held at the University of Washington School of Medicine, Seattle, Wash. The course will be a full five-day session relating current clinical and laboratory investigation to specific diagnostic and therapeutic problems in endocrinology. All registrations, requests for information, and application blanks should be sent to: Edward C. Rosenow, Jr., M. D., executive director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

American Board of Obstetrics and Gynecology

Applications for certification in the American Board of Obstetrics and Gynecology, letters requesting reopening of applications, and requests for reexamination are now being accepted in the office of the Secretary. All applications and letters of request must be submitted by July 1, 1964, and accompanied by duplicate lists of patients dismissed from service for the twelve months immediately preceding application.

Candidates are urged to carefully review the current Bulletin of the Board, with particular attention to the existing requirements before application is made. Bulletins may be obtained by writing to the office of the Secretary.

Diplomates are urged to keep the Board office informed of their current address. Address of the secretary is: Clyde L. Randall, M.D., Secretary-Treasurer, American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo 16, N. Y.

Southern Medical Association

Dr. Ben Senturia, chairman of the section of otolaryngology of the Southern Medical Association, announces that the guest speaker at the Memphis meeting on November 16–19 will be Dr. Arthur Maxwell Alden, St. Louis, Mo. Doctor Alden, emeritus associate professor of clinical otolaryngology, Washington University, St. Louis, Mo., will speak on "Otolaryngology: Then and Now."

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Hawaii Medical Seminar

The Hawaii Medical Association, which will sponsor a seminar directly following the 1964 A.M.A. San Francisco Convention, announces that a descriptive brochure is available from: the Hawaii Medical Seminar, Suite 300, 1612 K Street, Washington, D. C. 20006. An excellent program has been arranged with prominent speakers both from the mainland and the Hawaii Medical Association. The scientific sessions will be interspersed with an attractive program of entertainment and hospitality events. The seminar takes place June 26–July 1.

National Society for Crippled Children and Adults

The 1964 annual convention of the National Society for Crippled Children and Adults has been set for November 13–16 at the Statler–Hilton Hotel, Detroit. Focus of the convention will be on rehabilitation services and how the constantly increasing need for them can be expanded and improved. The important job that teen-agers are doing in working with the handicapped will receive special attention during the convention. A training institute for board members and staff of state and local affiliate Societies also is being planned.

Mount Sinai Hospital May Day

The annual Mount Sinai Hospital May Day program will be held in the hospital auditorium on May 28, beginning at 9:00 a.m. The chairman of the program is Dr. Robert A. Frisch, Milwaukee. The papers to be presented are: A Review and Evaluation of Medical and Surgical Mortality from Upper Gastrointestinal Hemorrhage at Mount Sinai Hospital—Between 1959–1964, by Drs. Edward A. R. Lord and Arthur E. Mallette; The Variable Course of Dermatomyositis, by Dr. Gerson C. Bernhard; Liposarcoma, by Dr. Paul A. Jacobs; Relationship Between Minnesota Multiphasic Personality Test and Surgical Success with Duodenal Ulcer Patients, by Dr. I. I. Cash; Pregnancy and Latent Diabetes, by Dr. A. M. Kurzon; A Study of Pulmonary Embolism, by Dr. Louis C. Bernhardt; Adrenogenital Syndrome, by Dr. Sanford Mallin; and Use of Peritoneal Irrigations in Renal Failure, by Dr. John D. Silbar.

The guest speaker will be Dr. Robert C. Hickey, head of the Department of Surgery, University of Wisconsin Medical School, Madison, who will address the group at 11:15 a.m.

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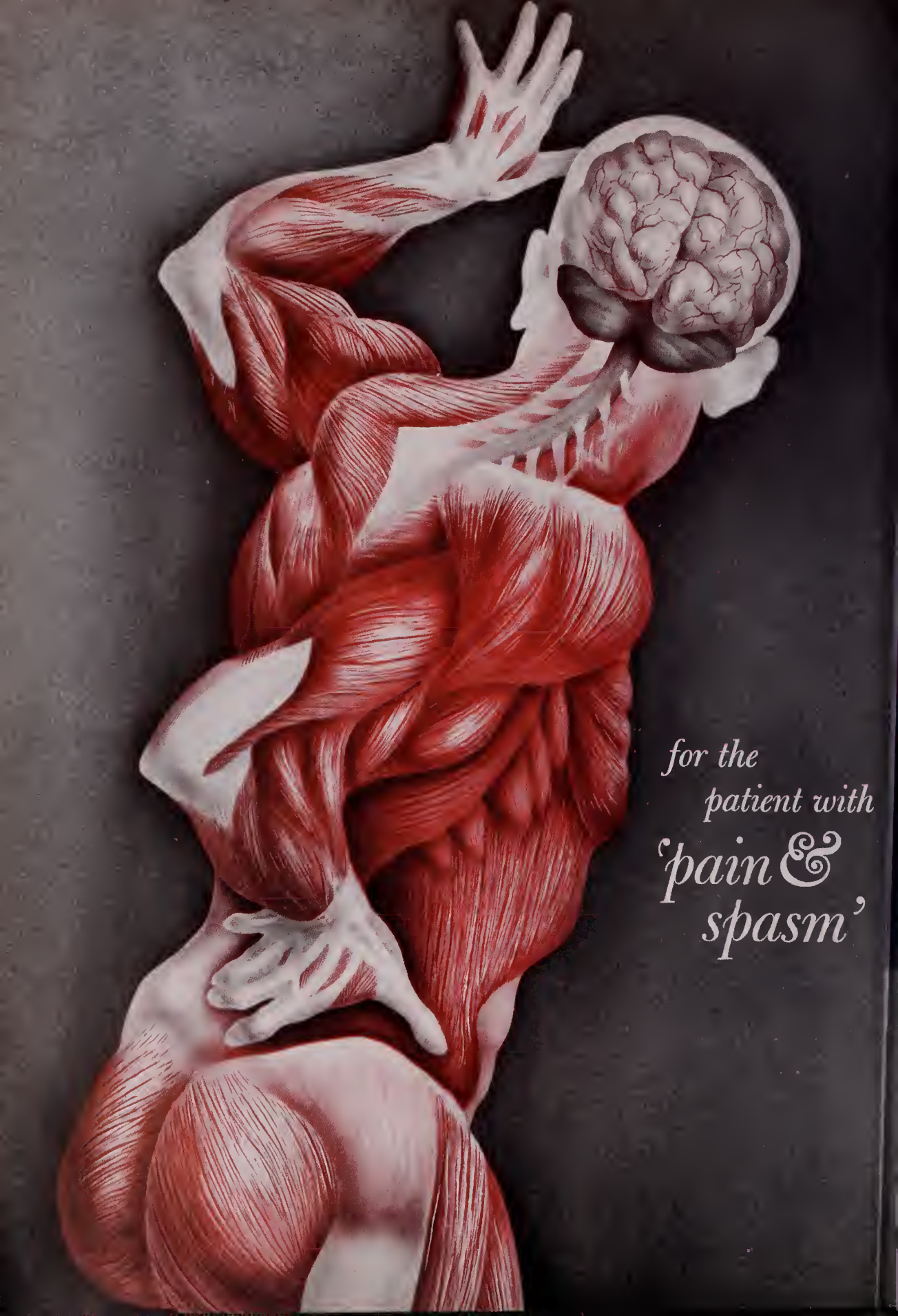
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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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COUNTY SOCIETY PROCEEDINGS

BROWN

The Brown County Medical Society met in the Northland Hotel, Green Bay, on April 2. Fifty physicians attended. A Sabin-on-Sunday program was discussed by the members, and an "Operation Hometown" film was shown.

CHIPPEWA

Dr. Ben Lawton, Marshfield, spoke to the Chippewa County Medical Society on the subject of the diagnosis and treatment of chest diseases at the Society's April meeting. The meeting was held at the Victory Memorial Hospital, Stanley.

DANE

The officers of the Dane County Medical Society Foundation for Medical Research have announced that funds are available for physicians interested in research projects. Quarterly deadlines (1st of January, April, July, and October) have been established for submission of applications for research grants. Applications will be reviewed by the directors within 30 days after each deadline and awards will be activated soon thereafter. The maximum amount of support for a single project has been set at $2,000. Requests for further information or instructions in preparing an application should be addressed to the secretary of the Foundation, William B. Parsons, M.D., 30 South Henry Street, Madison.

The following are new members of the Society.

Dr. Tamnit Ansusinha was born at Bangkok, Thailand, and received his medical degree from the University of Medical Sciences at Bangkok in 1957. He served his internship at Milwaukee County General Hospital and completed his residency in radiology at St. Luke's Hospital. Doctor Ansusinha is in private practice in Madison.

Dr. Gordon L. Eckert was born at Milwaukee, and graduated from the University of Wisconsin Medical School in 1957. He served his internship at Madison General Hospital and currently is in resident training in obstetrics and gynecology at University Hospitals.

Dr. Vincent L. Gott is a native of Wichita, Kan., and graduated from the Yale Medical School in 1953. He served his internship and completed his residency in surgery at University of Minnesota Hospitals. Doctor Gott is an associate professor of surgery at University Hospitals.

Dr. Ronald R. Kyllonen comes from Duluth, Minn., and received his medical education from the University of Minnesota where he graduated in 1957. He served his internship at Minneapolis General Hospital at Minneapolis, Minn., and completed his residency in child psychiatry at the University of Minnesota and at the Institute of Living at Hartford, Conn. Doctor Kyllonen is an assistant professor of psychiatry at the University of Wisconsin.

Dr. Rodney J. Sturm was born at Shawano, and graduated from the University of Wisconsin Medical School in 1956. He served his internship at St. Mary's Hospital in Madison and completed his residency in ophthalmology at the University of Wisconsin, Harvard, and at the University of Miami. Doctor Sturm is in private practice in Madison.

Physicians whose names appear in italics are members of the State Medical Society.

DOOR–KEWAUNEE

The Door–Kewaunee County Medical Society along with the Wisconsin Heart Association recently sponsored a congenital and rheumatic heart disease clinic at Memorial Hospital, Algoma. *Dr. Sherburne F. Morgan,* Milwaukee, and *Dr. Adolph M. Hutter,* Fond du Lac, examined about 25 patients who were referred to the clinic by their physicians.

DOUGLAS

The Douglas County Medical Society met in Superior on April 1 at Cronstrom's Supper Club. The speaker was Glenn C. Waldschmidt, regional representative of the State Medical Society, who presented a movie entitled "Medicare." This meeting was a joint one with the Douglas County Dental Society and the Pharmacists of the City of Superior.

KENOSHA

The regular monthly meeting of the Kenosha County Medical Society was held May 7 at the Elks Club, Kenosha. *Dr. Miles Smith,* Milwaukee, addressed the group on "Burn Center Experiences."

LA CROSSE

The La Crosse County Medical Society met in La Crosse on April 20. The meeting was a joint one with the 7th Councilor District. *Dr. Derward Lepley,* associate professor of surgery, Marquette University School of Medicine, Milwaukee, discussed "Problems of Cardiac Surgery." Seventy-one were present.

MARATHON

The Marathon County Medical Society met in Wausau on April 27 at the Wausau Club. There were 40 present. The meeting was concerned with business only and resolutions and amendments were discussed and delegates instructed for the State Medical Society annual meeting in May.

COUNTY SOCIETY PROCEEDINGS *continued*

MILWAUKEE

At its February 25 meeting, the Board of Directors of The Medical Society of Milwaukee County approved the president's appointments to the University Liaison Committee for 1964. Members appointed by *Dr. Robert S. Haukohl* are: *Drs. J. S. Devitt*, chairman; *E. A. Bachhuber, Norbert Enzer, J. S. Hirschboeck, H. M. Klopf, B. G. Narodick, B. J. Peters, J. R. Regan, D. M. Ruch, F. J. Stoddard*, and *H. F. Twelmeyer*.

In other action, the Board approved appointment of the following to the Surgical Care Subscribers' Committee: *Drs. W. J. Egan, Norbert Enzer, H. C. High, E. W. Mason* and *A. C. Schmidt;* and Messrs. Edmund Fitzgerald, L. W. Grossman, Richard Herzfeld, Joseph Heil and Irwin Maier. The appointment of *Dr. Roman E. Galasinski* to the Inter-professional Committee was also approved.

The Society also met on March 3 at the War Memorial Center, Milwaukee.

OUTAGAMIE

The Outagamie County Medical Society met April 16 at the Riverview Country Club. Medical care for the aged was the topic with Dr. Robert C. Long, Louisville, Ky., an assistant professor at the University of Louisville School of Medicine as the speaker. The Society had as its guests the wives, dentists, and pharmacists and their wives.

PIERCE–ST. CROIX

The Pierce–St. Croix County Medical Society met April 21 at New Richmond, it was reported by *Dr. P. H. Gutzler*, River Falls, secretary of the Society.

RACINE

The Racine County Medical Society held its regular business meeting and dinner April 15 in Racine. The speaker was Dr. James Foristel, lobbyist for the American Medical Association. The Society met again on April 30 at St. Luke's Hospital, Racine, where instruction of delegates to the annual meeting of the State Medical Society was given.

WOOD

The Wood County Medical Society met for a quarterly meeting in Wisconsin Rapids on April 9. Mary Lou Linton, director of children's services for the Wood County Children's Board, and Raymond Keller, an employee of the Children's Service Society, spoke on "The Unwed Mother." Two Marshfield physicians, *Dr. John Mulvaney* and Dr. Walter Lauvsted, were accepted into the Society as transfer members from the Waupaca Medical Society and the Rochester, Minn., Medical Society, respectively. Following the meeting, the group toured the Consoweld Corporation plant.

Whether you're a teacher correcting exams. A student cramming for them. A housewife cleaning up after the kids. Or a businessman working late at night. Whoever you are, things go better when you pause and refresh with ice-cold Coca-Cola.

Marquette University Medical Alumni Association

Dr. Leo R. Weinshel, Milwaukee, has been installed as president of the Marquette University Medical Alumni Association. Named as vice-president was *Dr. George C. Schulte*, Kenosha, and as secretary-treasurer, *Dr. Kenneth F. Pelant*, of Grafton.

Milwaukee Surgical Society

The Milwaukee Surgical Society recently reelected *Drs. Philip H. Seefeld*, president; *John B. Hitz*, vice-president; and *Frederick J. Stoddard*, secretary-treasurer.

Milwaukee Gastroenterological Society

Officers recently elected by the Milwaukee Gastroenterological Society are: *Drs. Charles J. Sherkow*, president; *Edward S. Levy*, vice-president; and *Peter J. McNamara*, secretary-treasurer.

University of Wisconsin Medical Alumni Association

The University of Wisconsin Medical Alumni Association met May 11 in Juneau Hall of the Milwaukee Auditorium. *Dr. Ovid O. Meyer*, professor and chairman of the department of medicine, University of Wisconsin Medical School, Madison, delivered the main address: "Medicine Then, Now, and in the Future." He discussed developments and changes in the department during his 20 years as chairman, and his views on its future. The Association meeting was held in conjunction with the Annual Meeting of the State Medical Society.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society held its April meeting at the University Club, Milwaukee. The guest speaker was *Dr. Matthew Davis*, assistant clinical professor of surgery, Department of Ophthalmology, University of Wisconsin, Madison, who discussed "Pituitary Surgery for Diabetic Retinopathy." Election of officers was also held. The May 13 meeting, which was held jointly with the State Medical Society Section, was held at the University Club. Dr. Paul Chandler, clinical professor of Ophthalmology, Harvard Medical School, discussed "Choice of Treatment in Angle Closure Glaucoma."

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met in April at the University Club, Milwaukee. The featured speaker was Dr. Murray M. Copeland, University of Texas, M. D. Anderson Hospital and Tumor Institute, who discussed "Advances in Diagnosis and Treatment of Cancer." The May meeting, which was cosponsored with the National Kidney Disease Foundation, featured Drs. Neal S. Bricker, George E. Schreiner and Benjamin H. Spargo.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Heart Association

The Wisconsin Heart Association's 16th Annual Meeting, held June 16 at the Wisconsin Center Building, Madison, heard Dr. John H. Moyer, professor of medicine and chairman of the Department of Medicine, Hahnemann Medical College in Pennsylvania, as its guest speaker. Doctor Moyer talked on "Current Medical Management of Hypertension."

Outagamie County Tuberculosis Association

Dr. Richard P. Jahn, medical director of the Wisconsin Anti-Tuberculosis Association, spoke at the annual dinner meeting of the Outagamie County Tuberculosis Association April 29. The meeting was held in the Kaukauna Elks Club. Doctor Jahn's speech was entitled "Why Wait? Eradicate."

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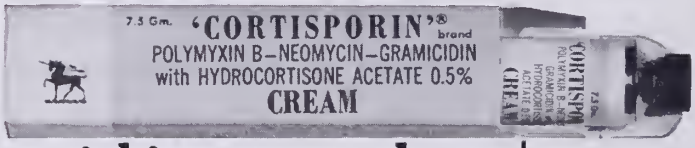

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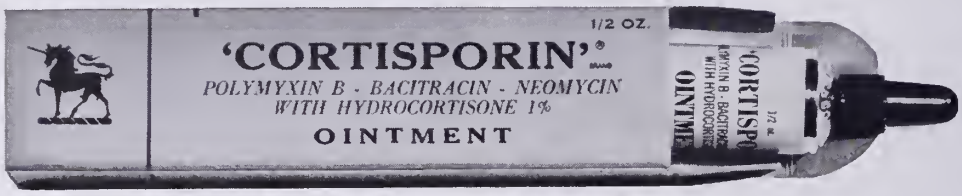

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NEWS OF WISCONSIN PHYSICIANS

Wisconsin Physicians on AMA Committees

Two Wisconsin physicians have recently been reappointed and one has been newly appointed to committees of the American Medical Association.

Dr. W. B. Hildebrand, Menasha, has been reappointed a member of the Commission on the Cost of Medical Care. The Commission is examining the factors which affect medical care prices, the total amount spent by the public for medical care, and the availability of the various medical services. The Commission will submit its report in June 1964. Research projects include those on "Changing Patterns of Hospital Care 1946–61," the economic significance of medical advances, and professional review mechanisms. The Commission will submit "Conclusions and Recommendations" as part of its final report.

Dr. Oscar A. Sander, Milwaukee, has been reappointed a member of the Committee on Rating of Mental and Physical Impairment. This Committee develops a series of practical guides to assist physicians in evaluating permanent impairment of body systems or organs. Each guide is prepared by a group of specialists for the specific body system under consideration. To date five guides have been published and have met with wide acceptance. Two additional guides will be published soon.

Dr. Ewald Pawsat, Fond du Lac, has been appointed a member of the Council on Voluntary Health Agencies. This Council maintains liaison between the AMA and national voluntary health agencies. The Council takes an active interest in national studies and programs concerned with the activities of national voluntary health agencies. It offers services to national voluntary health agencies on matters concerned with medical care, medical research, health education and medical profession relationships, and also provides physicians and medical societies with information concerning these agencies. On September 17–18 the Council will sponsor a national voluntary health conference in Chicago. Participants will include national leaders in medicine and the allied professions and representatives from the voluntary health agencies, governmental health agencies, labor, and industry.

Chetek Physicians Again Sears Preceptors

Doctors Robert Adams and *Joseph Powell,* Chetek, will again act as preceptors for a medical student who has received a Sears–Roebuck Foundation Preceptorship Scholarship. Gerald C. Freeman, a student from Nebraska College of Medicine at Omaha, will work with the doctors from July 1 to August 31. Mr. Freeman was one of 10 students chosen among 55 applicants by the Medical Advisory Board of the Sears–Roebuck Foundation.

Under the Student American Medical Association–Foundation Preceptorship program selected medical students to practice for two months in communities having participated in the Community Medical Assistance Program. These communities have constructed the uniquely designed medical center and have obtained a physician. Each recipient receives $500 from the Sears–Roebuck Foundation and room and board from the community or the physician. It is the purpose of this project to expose medical students to a rural practice where they can observe both the challenging aspects of such a practice and work in extremely modern facilities.

The Sears–Roebuck Foundation recently surveyed the Amherst community as a possible location for a Sears-designed medical center. However, the survey did not show sufficient potential for further cooperation.

Participate in AMA Meeting

A Wisconsin physician will participate in the half-day general scientific program covering glandular disturbances during the American Medical Association's 113th annual convention in San Francisco, June 21–25. The program will be offered at 9 a.m. on Monday, June 22, in Nourse Auditorium of the High School of Commerce.

The physician is *Dr. Edwin H. Ellison,* president of the Society of University Surgeons and chairman of the Department of Surgery at Marquette University School of Medicine, Milwaukee.

Doctor Ellison and Dr. Robert M. Zollinger, past president, hold a secure place in medical history as co-discoverers of the Zollinger–Ellison syndrome which is characterized by gastric hyperacidity, peptic ulceration and pancreatic tumors. These components were first correlated as a syndrome by Zollinger and Ellison in 1955.

Doctor Ellison, at 45, is considered one of the country's best young investigators in the field of surgery. Doctor Ellison is modest about himself and his work, but he speaks with pride about the University Surgeons' group. The 175-member society is one of the profession's most select organizations. To be accepted for membership, a candidate must be under 45 and have held an academic rank no lower than Assistant Professor for two years or more. In addition, he must give evidence of scientific creativity. The members make up a roll call of some of the most outstanding names in modern surgery.

Doctor Ellison will act as moderator for a panel discussion on Some Endocrine Aspects of Gastrointestinal Disease, at 11 a.m. Doctor Zollinger will talk on the Zollinger–Ellison Syndrome at 10:20 a.m.

Physicians whose names appear in italics are members of the State Medical Society.

First Aid Instruction

—Photo by Frank Ludowise, DELAVAN ENTERPRISE

Pictured are members of a Delavan High School first aid class who recently received instruction from Dr. Glenn Smiley, left, Delavan physician and surgeon. Doctor Smiley supervised while a closed cardiac massage and a mouth-to-mouth artificial respiration procedure were administered on a manikin.

Dr. Weston Is Chief of Staff

Dr. C. L. Weston, New Lisbon, was elected recently to the post of chief of staff at Tomah Memorial Hospital.

Mosinee Obtains Physician

It has been announced that Mosinee has obtained a physician, having been without one since February 8. Dr. A. J. Hockett, a graduate of the University of Oregon Medical School and former director of Touro Hospital, New Orleans, La., has come to Mosinee from Wallowa, Ore., where he had been practicing. Doctor Hockett served his internship and residency training at the University of Wisconsin General Hospital, Madison.

AMA Appointees

The American Medical Association has appointed two Madison physicians to national committees. They are *Dr. Francis M. Forster*, who was named to the rehabilitation committee, and *Dr. Ovid O. Meyer*, who was reappointed to the cost of medical care commission.

Japanese Surgeon Visits

Dr. Shoen Cho, a Japanese surgeon, and his wife visited recently in Madison as guest of *Dr.* and Mrs. *Arnold S. Jackson*. Doctor Cho, who was on a lecture tour of this country prior to attending the world meeting of the International College of Surgeons in Vienna in May, spoke at a dinner for the staff of the Jackson Clinic, Madison. Doctor Cho discussed recent developments in stomach surgery in Japan.

MEDICAL STAFF

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Dr. Nause Cited

—Photo courtesy of SHEBOYGAN PRESS

Dr. Fred A. Nause, right, Sheboygan, retiring as Sheboygan County civil defense medical director, a post he has held for many years, was praised recently for his long service to the program. He is being succeeded by *Dr. Jerry W. McRoberts*, Sheboygan, second from right. Others from left are James P. Smyth (foreground), county civil defense director; Louis E. Remily, Madison, director of civil defense health services, and Robert A. Hensen, Watertown, area director for civil defense in 28 counties.

Dr. Joseph Appointed to Hillview Home

Dr. Leo G. Joseph, La Crosse, has been appointed as the new physician at Hillview Home. The La Crosse County Board approved Doctor Joseph to succeed *Dr. Robert E. Flynn*, La Crosse, who will retire July 1.

Dr. Bennett Promoted

Dr. M. G. Peterman, Milwaukee, reported that Dr. Jack Bennett, formerly of Burlington, head of Roentgenology of St. Mary's Hospital, San Francisco, Calif., has recently been promoted to associate professor of roentgenology at the University of California Medical School. His brother, Dr. James Bennett, professor of surgery at Ohio University Medical School, Columbus, has accepted an appointment as professor of surgery at the University of Indianapolis, Ind., to be chief of plastic surgery. The father of these two men is still in active practice in San Leandro, Calif.

Dr. Cyrus Speaks on Head Injuries

Dr. Andrew E. Cyrus, Jr., chief of neuropathology of the Department of Pathology, Marquette University School of Medicine, Milwaukee, spoke recently on head injuries and the use of urea at the meeting of the Plymouth Hospital staff.

St. Francis Hospital Holds Open House

St. Francis Hospital, Milwaukee, held a special open house on May 14 in observance of National Hospital Week. Demonstrations of hospital equipment and supplies were seen in its auditorium. A miniature hospital convention was held for the day during which physicians, employees, their families, nursing schools and nursing school students, as well as the general public were invited and given the opportunity to meet and discuss with representatives from various companies the equipment supplies being demonstrated.

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1964 **Wisconsin**

June 13: Wisconsin Heart Association, Annual Meeting and nurses and closed chest resuscitation seminar, Wisconsin Center Building, Madison.

June 18–20: University of Wisconsin Postgraduate Program on Community Psychiatry, Wisconsin Center Building, Madison.

June 19–Aug. 3: Cardiovascular Disease Nursing Course, Marquette University School of Nursing, Milwaukee.

July 12–Aug. 2: Diabetes Association of Greater Chicago, summer camp for diabetic children, Holiday Home, Lake Geneva, Wis.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

Oct. 15–17: American College of Obstetricians and Gynecologists, District VI meeting, Milwaukee.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

1964 **Out-of-State**

June 17–20: Society of Nuclear Medicine, 11th annual meeting, Claremont Hotel, Berkley, Calif.

June 21–25: 113th annual convention of the American Medical Association, San Francisco, Calif.

June 22–25: Catholic Hospital Association convention, New York City.

June 24: Joint Planning of Patient Care by Physicians and Nurses in the Hospital and Home, AMA annual convention, San Francisco, Calif.

June 26–July 1: Hawaii Medical Association seminar.

Aug. 2–14: Israel Medical Association, 6th World Assembly, Haifa, Jerusalem, and Tel-Aviv, Israel.

Aug. 3–7: University of Colorado School of Medicine, 7th annual postgraduate course in pediatrics, Stanley Hotel, Estes Park, Colo.

Aug. 24–27: American Hospital Association, Chicago.

Aug. 24–28: International Conference on Preventive Cardiology, University of Vermont, Burlington, Vt.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 17–19: Fifth National Cancer Conference, Philadelphia, Pa.

Sept. 21–25: Animal Care Panel, 15th annual meeting, Hilton Hotel, New York City.

Sept. 30–Oct. 2: Florida Diabetes Association, Seminar on diabetes and related endocrine disorders, Balmoral Hotel, Miami Beach, Fla.

Oct. 1964–Mar. 1965: Biweekly courses in Continuing Education Program in Psychiatry and Psychotherapy, Mount Sinai Hospital, Chicago, Ill.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 22–24: American College of Gastroenterology annual course in postgraduate gastroenterology, The Roosevelt, New York, N.Y.

Oct. 26–29: National Safety Congress, Chicago.

Nov. 3–7: American Society of Oral Surgeons, Forty-Sixth Annual Meeting, Las Vegas, Nev.

Nov. 13–16: 1964 annual convention of National Society for Crippled Children and Adults, Statler–Hilton Hotel, Detroit, Mich.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

1965

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

1966

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

ACG Course in Postgraduate Gastroenterology

The annual course in Postgraduate Gastroenterology of the American College of Gastroenterology (ACG) will be given at The Roosevelt in New York City, October 22–24. The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum. A clinical session will be held at Mt. Sinai Hospital in addition to the several individual papers to be presented. For further information and enrollment, write to the American College of Gastroenterology, 33 West 60th Street, New York, N. Y. 10023.

American Heart Association International Society of Nephrology

The Third International Congress of Nephrology will be held from Sept. 26–30, 1966, in Washington, D. C. This was announced by the American Heart Association whose Council on Circulation (Section on Renal Disease) is cosponsoring the Congress with the International Society of Nephrology.

In this regard, the Council's Section on Renal Disease announced that its membership rolls are now open to scientists who are interested in the various disciplines pertaining to the kidney.

A grant from the National Institutes of Health to the Section on Renal Disease enabled some 27 scientists to travel to the Second International Congress of Nephrology in Prague last year. In addition, the Section represented the Association at a conference on chronic uremia in New York last June and sponsored programs and films at the AHA Annual Scientific Sessions in Los Angeles last October.

Applications for membership in the Council's Section on Renal Disease or further information concerning the Congress of Nephrology may be obtained from Douglas M. Smith, Administrative Associate, American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.

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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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International Conference on Health and Health Education

"The health of the community and the dynamics of development" will be the theme of the Sixth International Conference on Health and Health Education to be held in Madrid, Spain, July 10–17, 1965, under the sponsorship of the International Union for Health Education.

A large delegation from the United States is expected to participate in the Madrid meetings, which will include technical study groups and tours of health and education facilities as well as the usual plenary and related sessions. Plans are underway by ANCHEP for organization of charter air flights from New York City to Madrid, and for professional study tours.

Full details of the Conference, registration fees, hotel accommodations, special travel arrangements, are available from ANCHEP, 800 Second Avenue, New York, N. Y. 10017.

Society of Nuclear Medicine

The Society of Nuclear Medicine, an international organization comprised of physicians, chemists, physicists, biologists, and other scientists will hold its 11th Annual Meeting at the Claremont Hotel, Berkeley, Calif. (across the bay from San Francisco) June 17–20. The scientific program will include a series of refresher courses to be presented each morning. Many original papers dealing with the diagnostic, therapeutic, preclinical and radiobiological aspects of nuclear medicine will be presented during the three-day meeting. In addition to the original presentations, there will be four panel discussions dealing with side effects, diagnostic advances, space and volumes, and therapeutic advances.

Programs and additional information may be obtained by writing to Mr. Samuel N. Turiel, Administrator, Society of Nuclear Medicine, 333 N. Michigan Avenue, Chicago, Illinois 60601.

Patient Care to Be Discussed by Physicians–Nurses in San Francisco

"Joint Planning of Patient Care by Physicians and Nurses in the Hospital and Home" will be discussed in San Francisco June 24 during the 113th annual convention of the American Medical Association.

The 90-minute discussion, sponsored by the AMA's Committee on Nursing, will be held in Room D of the Civic Auditorium as a part of the convention's scientific program.

Jeanne C. Quint, R.N., assistant research sociologist, University of California San Francisco Medical Center, will present to the nurse-physician audience a formal paper on the subject.

Additional information may be obtained by writing: Department of Nursing, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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*Donnelly, J.: A.M.A. Arch. Environmental Health 6:697, June, 1963

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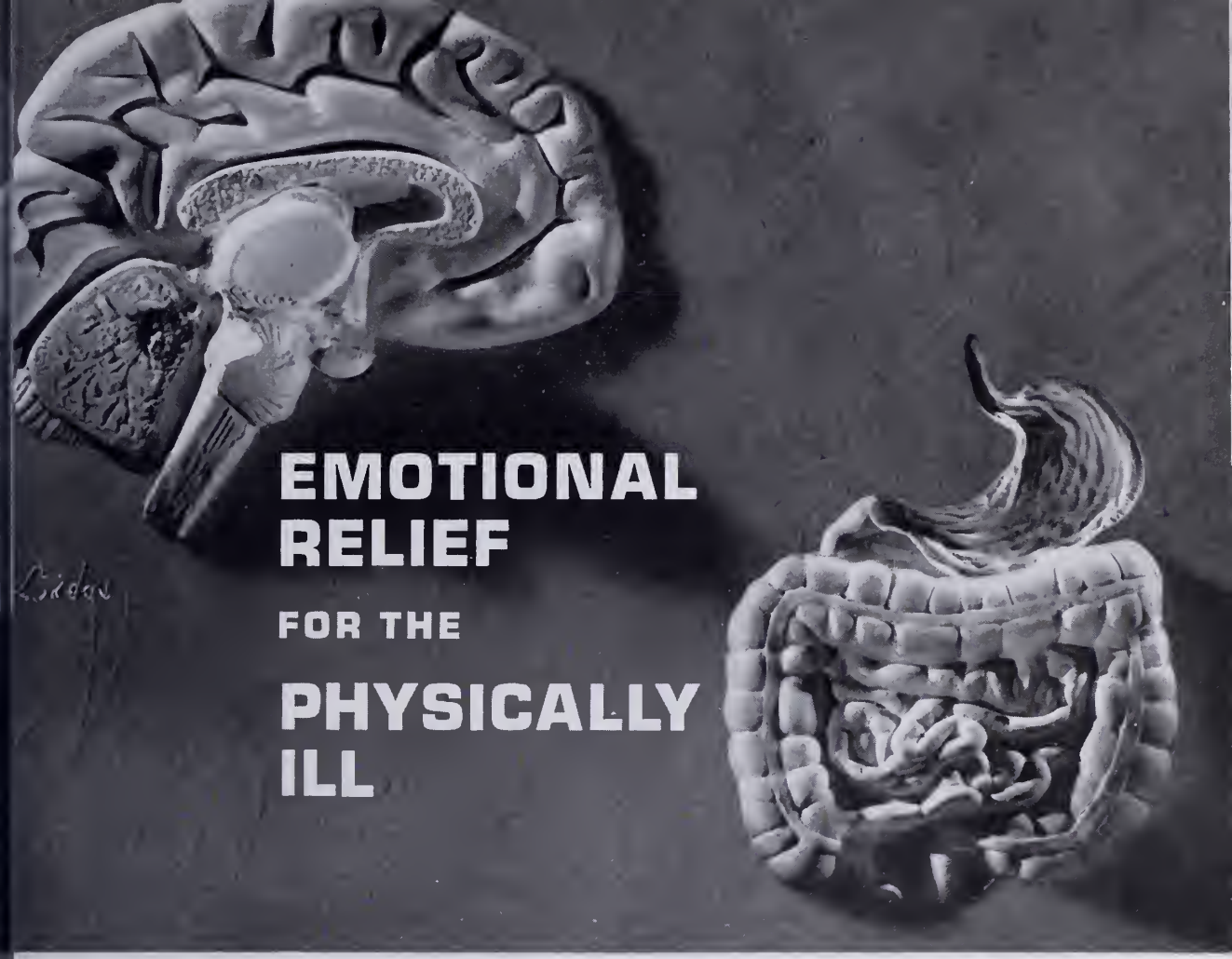

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Delegates to American Medical Association
(Terms end on December 31 of year indicated)

John M. Bell, Marinette, 1964
J. C. Fox, La Crosse, 1964
E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1965
A. A. Quisling, Madison, 1965
W. B. Hildebrand, Menasha, 1965

Alternates

C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1965

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	L. W. Moody Bayfield	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	H. O. Jirsa Cumberland	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	L. H. Edelblute 744 S. Webster Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	John A. Knauf Stockbridge	
Chippewa	Charles A. Kemper 727 Maple, Chippewa Falls	James L. Windeck 600 Bay St., Chippewa Falls	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	Palmer R. Kundert 110 E. Main St., Madison	Gordon Davenport, Jr. 110 E. Main, Madison	Second Tuesday**
Dodge	Norman Erickson 302 N. Spring St., Beaver Dam	N. H. Schulz 317 E. Lake St., Horicon	Last Thursday*
Door–Kewaunee	W. S. Hobson 23 S. Madison, Sturgeon Bay	David Papendick 801 Fourth St., Algoma	
Douglas	Thomas J. Doyle 1507 Tower Ave., Superior	Oscar Farias Hawthorne	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	Harold Kief 104 So. Main St. Fond du Lac	W. G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	Carol E. Mueller Boscobel	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	John M. Irvin 2101 6th St., Monroe	Frank C. Stiles 921 16th Ave., Monroe	
Green Lake–Waushara	Russell C. Daroy Wautoma	Roy Hong Wild Rose	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	E. J. Hohler Mineral Point	H. P. Breier Montfort	First Thursday following first Monday
Jefferson	J. J. Harris 311 N. Main, Ft. Atkinson	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	G. A. Sattler 6401 Sheridan Rd., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Grosse	Frederick H. Wolf 419 Main St., La Grosse	Ruth Dalton St. Francis Hosp., La Grosse	Third Monday
Lafayette	L. J. Unterholzner Box 115, Blanchardville	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Gromer 824½ Fifth, Antigo	Earl J. Roth 606 Superior, Antigo	First Monday
Lincoln	William Braun 412 W. Main St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	Charles E. Wall 904 South 8th St. Manitowoc	G. H. Stannard, Jr. 1425 Grinnell Rd. Manitowoc	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	Charles Koepp 516 Houston St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Robert S. Haukohl 620 N. 19th St., Milwaukee	Donald P. Babbitt 2701 E. Beverly Rd., Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	Michael Barton 907 Main St., Oconto	
Oneida–Vilas	George F. Pratt Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	Jack G. Anderson 424 Longview Ave. Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday* Elks Club
Ozaukee	Kenneth F. Pelant 1240 13th Ave., Grafton	Allen Misch 204 N. Washington St., Cedarburg	
Pierce–St. Croix	Ernest Drury New Richmond	P. H. Gutzler River Falls	Third Tuesday
Polk	Lloyd Olson St. Croix Falls	Paul Simenstad Osceola	Third Thursday 7:00 p.m.
Portage	R. H. Slater 401 Main St., Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	Frank J. Scheible 632 High St., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	George Parke, Jr. 323 So. Gentral Ave., Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	E. W. Remardy 2020 Milw. Ave., Janesville	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	I. A. Galarynk Plain	Gibbs W. Zauft 590 4th St., Prairie du Sac	Second Tuesday*
Shawano	H. F. Laufenburg Shawano	A. J. Sebesta 126½ S. Main St., Shawano	Third Wednesday
Sheboygan	Donald M. Rowe Kohler	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Albert Daniells 903 Filmore St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Joseph Syty Viroqua	G. A. Ender 120 W. Court St., Viroqua	Last Wednesday
Walworth	Henry F. Bischof 845 Main St., Lake Geneva	Rocco S. Galgano 610 Walworth, Delavan	Second Thursday*
Washington	James Albrecht 118 E. Main St., Jackson	W. E. Scheunemann 626 Cedar St., West Bend	Fourth Thursday
Waukesha	Robert Monk 217 Wis. Bldg., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	Kenneth L. Haman Waupaca	Lloyd P. Maasch Weyauwega	
Winnebago	R. V. Kuhn 219 West 9th St., Oshkosh	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	George H. Handy P. O. Box 827 Wisconsin Rapids	John W. Rupel 630 S. Central, Marshfield	Four times a year

* Except June, July and August.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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Journal
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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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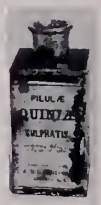

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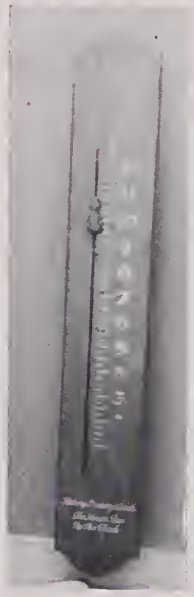

THANKS

DR. GORDON MARLOW, Madison, for the two Hickory Dickory Dock Clocks, one for display at the State Medical Society office and the other at the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien.

In an unusual basement workshop Doctor Marlow engages in his hobbies of restoring old nickelodeons, and he's an expert at making and repairing clocks. He has an old time grandfather clock, more than 8 feet tall, which he put in running order.

His "hickory dickory dock" clock, for which a patent is pending, is patterned after the old nursery rhyme. It is a long rectangle with a mouse climbing up it. When the clock strikes one, the mouse falls down, and has to start all over again.

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MANUSCRIPTS AND PAPERS

MEDICAL MUSEUM

COUNTY SOCIETY PROCEEDINGS

BROWN

A business meeting, dinner and program were held by the Brown County Medical Society May 21 at the Northland Hotel, Green Bay. John Bartmann, physical director of the Green Bay YMCA, spoke on the theme, "Health Through Physical Fitness." Two days prior to the regular meeting, members of the society enjoyed a golf outing and dinner at Oneida Golf Club.

DANE

"Pain Relief in Malignant Disease" was discussed by *Dr. R. S. Barreto* at the April meeting of the Dane County Medical Society. Doctor Barreto is an assistant professor of anesthesiology at the University of Wisconsin Medical School, where he is in charge of the "Pain" and "Block" clinics.

New members of the society are:

Dr. John B. Davis, a native of Washburn who graduated from the University of Wisconsin Medical School in 1954. He served his internship at Madison General Hospital and completed his residency at Columbia Hospital in Milwaukee. Doctor Davis practices radiology in Madison.

Dr. Frances E. Ehrlich was born in New York City. She graduated from the Union University Albany Medical College in 1949 and completed her internship at Gouverneur Hospital in New York. Doctor Ehrlich completed her residency in pediatrics and psychiatry at Detroit Childrens, Buffalo Childrens, and Mendota and University Hospitals, and currently is employed at Mendota State Hospital.

A native of Berlin, Germany, Dr. Werner Langheim graduated from the Medical School of the University of Hamburg, Germany, in 1954 and completed his residency in neurological surgery at University of Hamburg and Hamburg–Altona Hospital and at the Mayo Clinic and University Hospitals. Doctor Langheim is a staff member of the Veterans' Hospital in Madison.

Dr. Charles C. Lobeck was born at New Rochelle, N.Y., and received his medical degree at the University of Rochester School of Medicine and Dentistry in 1952. He served his internship at Grace New Haven Community Hospital in New Haven, Conn., and completed his residency in pediatrics at Strong Memorial Hospital. Doctor Lobeck is chairman of the Department of Pediatrics at University Hospitals.

DOUGLAS

Nineteen members attended the May meeting of the Douglas County Medical Society at the Saratoga Cafe in Superior. A report on the 16th annual assembly of the American Association of Chest Physicians, in Atlantic City, was presented by *Drs. Charles J. Picard* and *Richard P. Fruehauf* of Superior.

Physicians whose names appear in italics are members of the State Medical Society.

GRANT

At a recent special meeting, the Grant County Medical Society decided to donate 40 per cent of an unanticipated residue of Sabin-on-Sunday funds to the Charitable, Educational and Scientific Foundation of the State Medical Society. These funds will be used for student loans to needy Grant county residents seeking careers in medicine, dentistry, pharmacy, nursing, or other related fields.

With the administration of Type II Sabin Oral Polio Vaccine on May 17, 100,000 doses of all three types of the vaccine had been given in Grant County, constituting 75 per cent of the population.

LA CROSSE

Dr. Graham Miller of the Mayo Clinic presented a paper on "Some Aspects of Left Heart Volume Studies in Congenital and Acquired Heart Disease" before the May meeting of the La Crosse County Medical Society. During the business session, a report was heard on the House of Delegates annual session, and announcement was made that the 1966 meeting of the State Medical Society will be held in La Crosse. Sixty were present at the meeting at The Fireside.

OUTAGAMIE

A panel of doctors and attorneys discussed mutual problems in a program following the dinner held by the Outagamie County Medical Society and the Outagamie County Bar Association in May at Appleton.

RACINE

The regular meeting of the Racine County Medical Society was held May 28 at St. Luke's Hospital in Racine. On the agenda for the business meeting were reports of delegates and a fee schedule discussion.

NINTH COUNCILOR DISTRICT

Dr. G. G. Shields of Wisconsin Rapids was elected president for the coming year to succeed *Dr. E. P. Ludwig* of Wausau when the Ninth Councilor Medical District met May 28 at the Hotel Whiting in Stevens Point. *Dr. F. E. Gehin* of Stevens Point was reelected secretary-treasurer.

Dr. William P. Curran, new president of the State Medical Society, was a guest and spoke at the meeting.

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SPECIALTY SOCIETY PROCEEDINGS

Dodge County Medical Assistants Society

Dodge County Medical Assistants Society members heard the immediate past president of the American Association of Medical Assistants, Miss Alice Budny, R.N., of Milwaukee, during a dinner meeting in May at Beaver Dam. Miss Budny presented the structure of the A.A.M.A. education and certification program.

On the program with Miss Budny were *Dr. William Funcke*, Beaver Dam, medical director for the Dodge County Civil Defense, who outlined the present structure of the disaster medical plan, and Miss Edith C. Murphy, Milwaukee, president of the Wisconsin State Medical Assistants Society, who spoke briefly on the state membership growth during the past year.

Among those welcomed by Mrs. Madeline Stebbins, Beaver Dam, president of the Dodge County Medical Assistants Society, were Doctor Funcke, *Dr. Darrell Link*, Beaver Dam, adviser to the county medical assistants society, and *Dr. Norman Erickson*, Beaver Dam, president of the Dodge County Medical Society, and Mmes. Erickson, Funcke, and Link.

Ozaukee–Sheboygan Medical Assistants Society

Officers elected at the April meeting of the Ozaukee–Sheboygan County Medical Assistants Society were installed by the Manitowoc Chapter of the Medical Assistants Society at the annual installation banquet June 18 in Mishicot.

Elected to office at the monthly meeting in Sheboygan Falls were Mrs. Eleanor Schaut, president; Mrs. Luella Hoffmann, president-elect; Miss Sojan Dittrich, treasurer; Mrs. Ceil Schmeckel, corresponding secretary; Miss Mary Imig, recording secretary.

Wisconsin Society of Pathologists

The summer meeting of the Wisconsin Society of Pathologists was held June 12–13 at Boulder Inn, Lake Lawn Lodge, Delavan.

On the evening of June 12, a socio-economic forum featured the subject of relationships of pathologists with professional colleagues, patients, institutions, teaching and research, and the community.

The following afternoon, *Dr. Byron Myhre* of Milwaukee discussed "Immunoelectrophoresis" and he also appeared with *Dr. Robert A. Scheidt* of Milwaukee in a discussion of "Laboratory Gadgetry." A former Wisconsin resident, Dr. Paul R. Glunz of Silver Spring, Md., spoke on the topic, "Hepatitis—What Manner of Beast."

The annual fall meeting of the society is slated for Saturday, Nov. 14, at Marquette University School of Medicine in Milwaukee.

Louis Romuald Named Director of WAMT

Louis Romuald, Fond du Lac, has been elected to a two-year term on the board of directors of the Wisconsin Association of Medical Technologists.

Elected and installed with Romuald at the spring convention in Madison were Stavri G. Joseph, Milwaukee, president; John Gerberich, Eau Claire, president-elect; Miss Patricia Jakus, Milwaukee, secretary; and Miss Joan Willard, Milwaukee, treasurer. Norman Du Chateau, Oshkosh, was also voted to serve on the board.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Becker Heads Society of Surgeons

Dr. Norman O. Becker, Fond du Lac, was elected to succeed *Dr. C. M. Schroeder* of Milwaukee at the annual meeting of the Wisconsin Surgical Society in Milwaukee. Dr. Becker said a September session will be held in Madison by the society, which is comprised of 175 certified surgical specialists.

Other officers are *Dr. Irwin Schulz*, Milwaukee, president-elect; *Dr. John T. Mendenhall*, Madison, secretary-treasurer; and *Dr. Sigurd Gundersen, Jr.*, La Crosse, recorder.

Diabetes Society Hears Dr. Beck

The Northeastern Wisconsin Diabetes Lay Society heard *Dr. Karl Beck* of Milwaukee speak on the topic, "Camp Programs for Diabetics," at an educational program for the public held at the Green Bay Y.M.C.A. Dr. Beck is a clinical instructor in pediatrics at Marquette University School of Medicine and one of the founders of the Wisconsin Diabetes Association.

SBH with SMS Provides Teaching Program for Osteopaths

On June 21 the Maternal Mortality Study Committee, at the request of the Bureau of Maternal and Child Health of the State Board of Health, provided a one-day teaching program for 52 osteopaths and nurses associated with osteopathic hospitals, in Milwaukee.

The program consisted of lectures and discussions on the subjects of ruptured uteri, hemorrhage, malposition, infections, and toxemia. Instruction was provided by members of the Maternal Mortality Study Committee: *T. A. Leonard, M.D.; George Kilkenny, M.D.; William Kreul, M.D.; John Evrard, M.D.; F. J. Hofmeister, M.D.;* and *Richard Mattingly, M.D.*

Cases associated with the Maternal Mortality Survey were used as the basis of the lectures and discussion.

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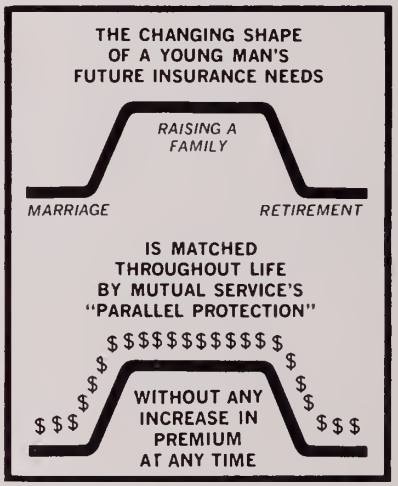

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NEWS OF WISCONSIN PHYSICIANS

Dr. Shahrokh Speaks to Staff Meeting

Dr. Darius K. Shahrokh, otolaryngologist of the Fond du Lac Clinic, gave a fully illustrated talk about modern surgical treatment for deafness on April 7 at the monthly staff meeting of Ripon Municipal Hospital. Using slides of his own drawings in his presentation, he discussed stapes surgery, myringoplasty, and stressed the seriousness of serous otitis media when neglected in children. Doctor Shahrokh also made a slide presentation at the monthly meeting of Sigma Group in Fond du Lac explaining what the public should know about the problem of deafness and its treatment.

Dr. Kagen Certified

Dr. Allan E. Kagen, Milwaukee, has recently become certified by the American Board of Neurological Surgery, having successfully passed the examination on April 13 in Chicago, Ill.

Dr. Fauerbach Too Busy to Retire

Dr. Louis P. Fauerbach, Madison, has apparently gathered responsibilities with the years rather than shedding them, according to a recent feature article in the Madison CAPITAL TIMES. He not only continues his own active practice, but has had his retirement from the Madison City Health Department postponed and also has taken over the presidency of the local Fauerbach Brewing–Pepsi Cola Company.

Louis Fauerbach, M.D.

As an aide to the City Health Officer, Doctor Fauerbach worked chiefly in tuberculin testing in Madison schools. It is estimated that he has tested a half-million school children since 1930. When he was about to retire from his post in December 1963, *Dr. C. K. Kincaid*, City Health Officer, requested and was subsequently granted a postponement. Three years ago, at an age when most men retire from business activity, Doctor Fauerbach assumed the presidency of the family-owned brewing company.

Doctor Fauerbach merely shrugs off the gruelling pace he must keep, and takes time, however limited, to indulge his favorite hobbies. These include hunting and fishing and outboard motor trips, plus enjoying the time spent with his wife working in the flower beds around their home.

Doctor Fauerbach, a dedicated physician and one with an optimistic outlook, does, however, remember the darker days of medicine. He took his internship in 1918–1919 at Bellevue Hospital in New York City and recalls the dreadful influenza epidemic in which "people died in their homes and hospitals faster than they could be removed." But Doctor Fauerbach, like medicine, has come a long way and accomplished much since then.

Glaucoma Presentations

Presentations dealing with glaucoma were made recently by *Dr. Lawrence L. Garner*, Milwaukee, before the annual convention of the Wisconsin Association of Licensed Practical Nurses at the Pfister Hotel, Milwaukee; the Pilot Club of Milwaukee, at the Athletic Club, Milwaukee; and the Langlade County Medical Society at Antigo.

In cooperation with the Neurological and Sensory Disease Service Program of the U. S. Public Health Service, Doctor Garner presented an exhibit and demonstrated the Technique of Tonometry using the Vision Interference Indicator at the American Medical Association convention, Section on Ophthalmology, June 21–25, in San Francisco. The exhibit is also sponsored by the Veterans Administration Regional Office, Milwaukee, the Glaucoma Referral Center, Marquette University School of Medicine, and the Wisconsin State Board of Health. Doctor Garner is director of the Glaucoma Referral Center.

$589,671 Cancer Grants to UW

Fifteen cancer research grants totaling $589,671 have been made to the University of Wisconsin by the Wisconsin Division of the American Cancer Society, according to *Dr. Gerard Uhrich*, La Crosse, chairman of the medical and scientific committee of the Society. Two research professorships, the highest award made by the Society, are in effect at the University of Wisconsin. One, for $115,550 is to Dr. Charles Heidelberger, and the other for $111,944 is to Dr. James Price.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Jerofke Leaves Nekoosa

Dr. Alfred Jerofke has terminated his association with the Nekoosa–Port Edwards Medical Group to take more work at Marquette University School of Medicine. He was associated with *Drs. Louis Pfeiffer* and *John Thompson*, and carried on a general medical practice in Nekoosa for three and one-half years. His two-year residency, which includes practice at the Wood Veterans Hospital, is designed to lead to a specialty in dermatology.

Dr. Bowers Resigns from UW Faculty

Dr. John Z. Bowers, former dean of the University of Wisconsin Medical School, has resigned his professorship to accept a job with the Rockefeller Foundation.

Dr. Cree Receives Award

Dr. Edna M. Cree, Fox Bluff, staff physician at the Madison Veterans Administration Hospital, has been awarded the "Administrator's Commendation" by J. S. Gleason, administrator of veterans affairs, for her achievements in the field of pulmonary emphysema. She was runner-up in the VA nomination for the 1964 Women's Federal award, a nationwide recognition program honoring women in government. The commendation was awarded to Doctor Cree "in recognition of her extraordinary dedication by which she has brought about significant advances in the study, control, and treatment of chronic obstructive pulmonary emphysema. As a nurse and later as a physician, she recognized the seriousness of this crippling disease and has devoted her career to its understanding and treatment." Doctor Cree has served at the VA Hospital since 1958, and is assistant clinical professor of medicine at the University of Wisconsin Medical School.

Dr. Jackson Attends European Meeting

Dr. Arnold S. Jackson, Madison, director of the Jackson Clinic, attended two meetings of surgeons in Europe in May. He went first to Vienna to participate in the session of the World Congress of the International College of Surgeons and then to London for several days to attend the meeting of the London group of the International College of Surgeons.

NIH Grants

National Institutes of Health (NIH) grants have been awarded recently to several members of the University of Wisconsin, Madison. They are: E. E. LeMasters, Ph.D.; Helmut Beinert, Ph.D.; Walter M. Fitch, Ph.D.; James F. Crow, Ph.D.; Barclay Martin, Ph.D.; Norman S. Greenfield, Ph.D.; Henry Weiss, Ph.D.; *Dr. Walter J. Urben*, and Dr. Robert F. Schilling.

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New Physician for Wautoma

Dr. Robert L. Demke, Westfield, has become the new physician at Wautoma. Doctor Demke has practiced for 4 years in Westfield, and prior to that for 10 years in Elroy. The Demke family has long been associated with medicine as both Doctor Demke's father and grandmother were physicians. Born in St. Charles, Ill., Doctor Demke studied at Arizona State College and the University of North Dakota. In 1947 he received his medical degree from Loyola Medical School, Chicago. He served two years in the U. S. Navy medical corps and spent one year with the public health service in Chicago.

Misericordia Plans New Hospital

Plans to build a new larger Misericordia Hospital in Brookfield have been announced. It will be located near the intersection of West North Avenue and North Brookfield Road. The eight-story building will provide a minimum of 250 beds, with the possibility of future expansion to 500 beds, according to Sister Ste. Marcienne, S.M., administrator. A separate building is planned to provide about 40 beds for unwed mothers-to-be. Although no date has been set, plans call for construction to begin in 1965.

AMA Speakers' Bureau Meeting

Drs. Robert E. Callan and *George E. Collentine, Jr.,* Milwaukee, were among 100 physicians from throughout the country invited to participate in the national A.M.A. Speakers' Bureau meeting in Chicago, in April. The meeting was held to brief the speakers on the status of current legislation and to provide advanced training in public speaking.

Dr. Chojnacki Appointed

Dr. S. L. Chojnacki, Milwaukee, has been appointed to serve a one-year term on the board of directors of Trinity College, Washington, D. C.

Dr. Schmidt on Alcoholism Council

Dr. Edward Carl Schmidt, Milwaukee, has been elected to serve a three-year term on the board of directors of the Milwaukee Council on Alcoholism.

Dr. Davidoff President of Staff

The Memorial Hospital, Milwaukee, medical staff recently elected *Dr. David E. Davidoff,* Milwaukee, as president and *Dr. Archie Tax,* Milwaukee, secretary, at its annual meeting.

Physicians Elected

Two Madison pediatricians have been elected fellows of the American Academy of Pediatrics. They are *Dr. Charles H. Geppert* and Dr. Thomas C. Meyer.

Attend Course

Drs. Marvin Wright and *Allen Johnson,* Rhinelander, attended a three-day postgraduate course in gynecology, with emphasis on endocrinology, which was held in Minneapolis, Minn., in April.

Glaucoma Test

—Photo courtesy of the EAU CLAIRE TELEGRAM

Dr. P. G. Spelbring, left, Eau Claire, tested for glaucoma recently at a clinic at Regis High School, Eau Claire, as Mrs. Gladys Andersan, ane of six assisting nurses, laaked an. Some 1,201 persans were tested with 19 pasitive or suspiciaus readings. This figure is under the natianal average of 2 per cent, but there may be other undetected cases in Eau Claire and additional clinics may be spansared. The City-County Health Department will fallaw up the suspected cases and determine the number of confirmed cases. Physicians wha valunteered their services were Doctor Spelbring, *Dr. David Miller* and *Dr. Gearge E. Miller,* Eau Claire; and *Dr. Frank J. Brawn,* Chippewa Falls.

Dr. Puchner Addresses Kiwanis

West Bend Kiwanis members heard a talk on "Environmental Factors in Heart Disease" at their luncheon meeting, April 21. The guest speaker was *Dr. Thomas C. Puchner,* Milwaukee internal medicine specialist, who appeared through the sponsorship of the Wisconsin Heart Association as part of its public education program.

Dr. Nereim Attends Meeting

Dr. T. J. Nereim, Madison, attended the American Academy of General Practice meeting held recently in Atlantic City, N. J.

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PHYSICIAN NEWS *continued*

Teen Smoking Program

"Smoking and the Teen-Ager" was the subject of a film and panel discussion held recently at the meeting of the Appleton Memorial Hospital Auxiliary. Participating were *Drs. C. E. Fenlon, Paul Hodges, Jr.,* and *Paul Cunningham,* all of Appleton.

Dr. Yoran Reelected to Wausau Chairmanship

Dr. C. M. Yoran was re-elected chairman at an organizational meeting of the Wausau Board of Health early in May.

Dr. Ousley Attended Post-Doctoral Session

Dr. Joseph L. Ousley, internist at the Marshfield Clinic, was one of 91 physicians from the United States and five foreign countries who enrolled for a post-doctoral course June 1–6 in Boston. The course, on "Basic Science and Its Relation to Internal Medicine," was offered at Peter Bent Brigham Hospital under the auspices of Courses for Graduates, Harvard Medical School.

Dr. Woloschek on WISN

Dr. Walter J. Woloschek of Milwaukee spoke on "Quackery" on WISN's "Sound of Ideas" interview in April in a discussion with the station's news director, Donald Froehlich, arranged by The Medical Society of Milwaukee County.

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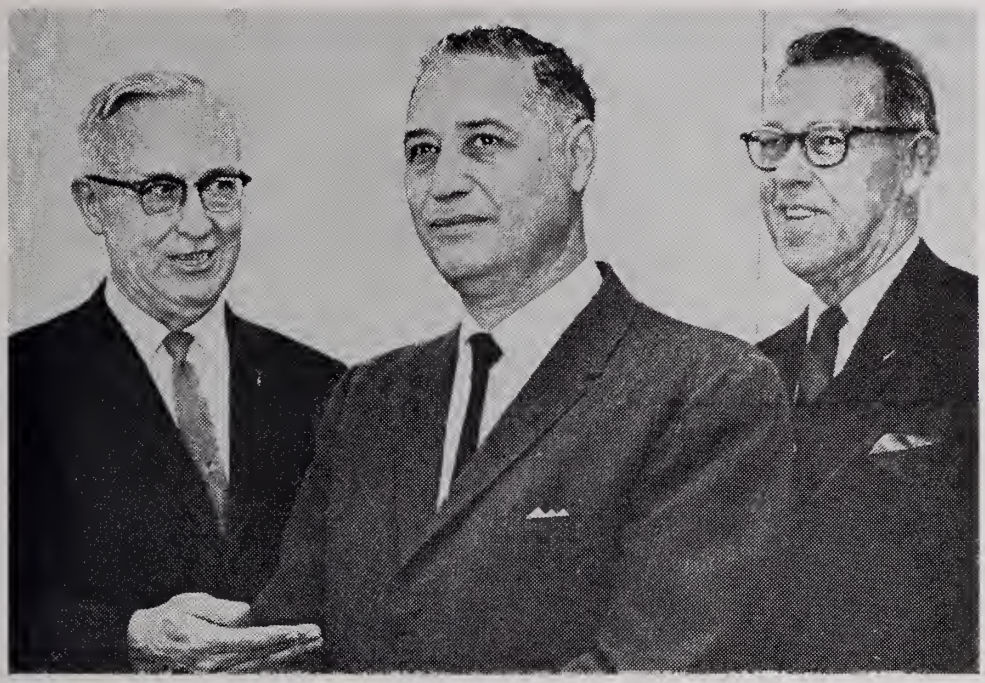

Courtesy WISCONSIN STATE JOURNAL

Cancer Society Honors Dr. Curreri

Dr. Anthany Curreri, center, receives a past president's oward from Arthur H. Mennes, left, president of the Done County Unit af the American Cancer Society, at an infarmal kickoff luncheon March 25 at Maple Bluff Country Club, Madison. Looking on ot right is Cyrus Johnson, Cancer Saciety Crusade chairman. Dactor Curreri, Madisan, is a past president of the Wiscansin Division of the American Cancer Society and is a member of the natianal board.

Wisconsin Physicians Honored by ACP

Five Wisconsin physicians have been honored by the American College of Physicians (ACP). Elected as fellows are: *Drs. Thorolf E. Gundersen*, La Crosse; *Philip B. O'Neill*, Milwaukee; and *John M. Irvin* and *Keith B. Witte*, Monroe. Elected as an associate is *Dr. Laurence G. Crocker*, Madison.

Dr. Lepley Speaks

Members of the Chartered Life Underwriters Association heard *Dr. Derward Lepley, Jr.*, associate professor of surgery, Marquette University School of Medicine, Milwaukee, at their dinner meeting May 4 at Aliota's Restaurant, near Burleigh. Doctor Lepley, a member of Wisconsin Heart Association's State Physician speakers bureau which sponsored his appearance, discussed "Advances in Heart Surgery—Resulting Effect of Heart Murmurs on Mortality."

Dr. Kagen Resigns as Health Officer

Dr. Marvin S. Kagen, Appleton, has resigned as Appleton's health commissioner after holding the post since 1959. Doctor Kagen is a dermatologist in Appleton.

Dr. Misch Again Health Officer

Dr. Allan Misch, Cedarburg, was reelected as health officer by the city board of health for the 1964–1965 year.

Dr. Boutwell Speaks to Optimists

Dr. R. K. Boutwell of the McArdle Laboratory Center, Madison, spoke recently on cancer to the Optimist Club in Madison.

Dr. Rafferty Joins Staff

Dr. Hugh Rafferty joined the La Crosse Clinic staff in May and is associated with *Dr. Ubaldo Alvarez* in the department of obstetrics and gynecology. Doctor Rafferty attended St. Norbert College, De Pere, before receiving his M.D. degree from Marquette University School of Medicine. He interned at St. Mary's Hospital, San Francisco, Calif., after which he joined the Navy medical corps and was attached to the 3rd Marine Division in Okinawa. After his tour of duty with the Navy, he spent the next three and one-half years as a resident at Providence Hospital, Detroit, Mich. Doctor Rafferty has been in private practice in Kenosha for the past three years. He is a member of the American College of Obstetricians and Gynecologists.

Dr. Belcher Resigns Post

Dr. Charles H. Belcher has resigned as superintendent of Winnebago State Hospital. Doctor Belcher, who began his superintendency at Winnebago in 1959, has accepted a position with the Mental Health Clinic, Honolulu, Hawaii. No successor has been named thus far.

Dr. Kelley Heads Recruitment

Dr. O. R. Kelley, Wausau, head of pathology at St. Mary's and Wausau Memorial hospitals and director of the Marathon County Blood Bank, has been named national student recruitment chairman for the University of Virginia Medical Schools, Charlottesville, Va. The committee is newly formed and will aim to seek top quality students from throughout the nation. A graduate of the school, Doctor Kelley has been in Wausau for 18 years. In his committee post, he will visit the University of Virginia several times yearly and will guide the screening of prospective students. *Dr. James C. Curry*, Appleton, has also been appointed to the advisory committee and will work with Doctor Kelley.

Dr. Suechting Addresses Nurses

Dr. Ralph Suechting, Neenah, spoke on "New Diagnostic Procedures for Neural Surgery" at the May meeting of the Appleton District Wisconsin Nurses Association.

ACOG Fellows Inducted

Dr. George Petersen and *Dr. Eugene H. Raney*, both of Appleton, were among 649 new fellows of the American College of Obstetricians and Gynecologists (ACOG) who were inducted into the College at the twelfth annual clinical meeting May 17–22 in Bal Harbour, Fla.

Elect Dr. Evrard

Dr. John Evrard, Milwaukee, has been elected chief of staff at St. Michael Hospital. *Dr. C. Hugh Hickey* was elected secretary-treasurer. Other new members elected to serve on the medical staff executive committee are *Dr. Herman Tuchman*, chief of internal medicine; *Dr. Gerald Mullaney, Jr.*, chief of obstetrics; Dr. Rex Ruppa, chief of pediatrics; and *Dr. Frank De Groat, Jr.*

Units Added at Stanley Hospital

Two new departments have been added to the facilities of Victory Memorial Hospital, Stanley, and several new pieces of equipment are now in use. The most recent addition is a pathology department, with *Drs. Robert J. Fink* and *Ray D. Reed*, pathologists from Eau Claire, at the hospital on alternate weeks. A physiotherapy department also has been added and a physiotherapist is at the hospital three days each week.

Rice Clinic Has Addition

The Rice Clinic, Stevens Point, has begun an addition which will add about 75 per cent to the area of the present building. The addition, which will have a full basement, will be built to the east of the present building. There are now six physicians on the clinic staff, and *Dr. M. G. Rice* said there are plans to add more.

New Medical–Dental Center

A new medical and dental center has been opened at 2453 Atwood Avenue, Madison, and houses two physicians and three dentists. It is owned by *Dr. Carl A. Fosmark*, Madison, and his brother, George, of DeForest. Doctor Fosmark, a general practitioner and surgeon, has moved into the new building from his old office where he had been since 1946. The other physician is *Dr. Everett L. Roley*, Sun Prairie, who moved into the new building.

Dr. Rosekrans Attends Medical Assembly

Dr. Sarah D. Rosekrans, Neillsville, left in May for Finland where she was an official observer of the United States at the 18th World Medical Assembly. While in Finland, she planned to meet friends, and travel on to visit Budapest, Odessa, Moscow, Leningrad, Prague, and Samarkand.

Dr. Ambrose Resigns

Dr. Stephen H. Ambrose, Whitewater State College physician since 1946, has resigned his post to devote more time to private practice.

Dr. Hoffmann Honored

Dr. J. Greg Hoffmann, Hartford, was honored recently at a dinner at the Linden Inn on Big Cedar Lake. The dinner marked his 60 years in the medical profession. The party was planned by the medical staff of St. Joseph's Hospital, Hartford. Visitors included *Dr. W. J. Egan*, Milwaukee, immediate past president of the State Medical Society; Representative William K. Van Pelt; Frank Panzer, Brownsville, president pro tem of the State Senate; Hartford Mayor Thomas J. Buckley; and Washington County Judge Lester Buckley, Hartford.

Doctor Hoffmann was born at Campbellsport, where his father was a physician for 50 years. His brother, *Dr. Leo Hoffmann*, who is now at Campbellsport, has been practicing for 45 years. Doctor Hoffmann studied medicine at the Wisconsin College of Physicians and Surgeons in Milwaukee which was taken over by Marquette University. He started internship at St. Joseph's Hospital, Milwaukee, in 1904, and went to Prairie du Chien in 1905. Later in 1905, he moved to Hartford. And, except for a stint as a captain in the medical corps in World War I, he has been there since. Doctor Hoffmann has been health officer of Hartford for 50 years. He estimates that he has delivered more than 2,000 babies.

Appleton Physicians on Program

Dr. Jack Anderson, Appleton internist and president of the Outagamie County Medical Society, and *Dr. W. R. Richards*, orthopedic surgeon of the same city, were on the program presented at Appleton in May when a man who spent 7½ years in bed with rheumatoid arthritis stood on the stage of Roosevelt Junior High School and told about 125 area arthritis sufferers and relatives that arthritics can lead active, productive lives.

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Jerry Walsh, now an educational consultant to the Arthritis and Rheumatism Foundation, was named Handicapped American of the Year by President Johnson for 1964. Stricken at the age of 18, he was put to bed where he stayed until he decided that he could do something about his arthritis. The discovery of cortisone was responsible for Walsh's awakening, but it was at the Mayo Clinic that he started his slow and painful recovery. Walking now with the aid of one crutch and one cane, Walsh travels about 150,000 miles a year in his work for the foundation.

A flood of questions from the audience were answered by Doctors Anderson and Richards during the program, which was cosponsored by the Appleton City Health Department.

Dr. Gorrell Gets Post at St. Luke's

Dr. John Gorrell of Rumson, N. J., has been named to the newly created post of medical education director at St. Luke's Hospital, Milwaukee, Gordon K. Flom, assistant administrator, announced. Doctor Gorrell was formerly on the staff of Monmouth Medical Center, Long Branch, N. J.

Dr. Laird New Appleton Health Officer

Dr. James W. Laird has been appointed as Appleton health commissioner succeeding *Dr. Marvin S. Kagen.* In the annual reorganization of the Appleton board of health, *Dr. Carl D. Neidhold* was reelected president for another year. Other officers include *Dr. Joseph L. Benton,* vice-president.

Therapists Hear Dr. Siebens

Dr. Arthur A. Siebens, director of the rehabilitation center of the University of Wisconsin Medical Center, was the featured speaker at a meeting of the Upper Midwest Physical and Occupational Therapists May 13 in St. Paul. More than 6,000 persons from five upper midwestern states and Manitoba, Canada, were expected to attend the three-day conference.

Dr. Engel New Holstein's 'Man of Year'

Dr. A. C. Engel was named New Holstein's "Man of the Year" at a recognition banquet sponsored recently by the New Holstein Association of Commerce. Over 200 persons gathered to honor Doctor Engel, a lifetime physician and surgeon of New Holstein who has an impressive record of having delivered more than 4,000 babies in his 40 years of practice in that city.

Five Waukesha Doctors Move to New Offices

Drs. Earl G. Schulz, Paul E. Carroll, Richard G. Frantz and *A. J. Motzel, Jr.,* are joint owners of the new $150,000 Moreland Medical Building in Waukesha. Occupying the building's three suites are Doctor Schulz, internal medicine; Doctor Frantz and Doctor Motzel, surgeons; Doctor Carroll and *Dr. Jack A. Peterson,* gynecologists. Doctor Peterson is a tenant. Doctor Schulz is installing a medical laboratory, but according to Doctor Motzel there are no plans to operate a clinic.

'Understanding Oldster' Is Dr. Horsley's Topic

The three-dimensional concept of man was outlined by *Dr. D. Boyd Horsley,* Brookside medical director, Kenosha, at the institution's first orientation for volunteers.

Addressing an audience which included 75 volunteers, Brookside Aulixiary members and Red Cross Gray Ladies, Doctor Horsley spoke on "Understanding the Oldster."

New Post for Dr. Musser

The Veterans Administration in Washington has announced appointment of Dr. Marc J. Musser to the post of deputy chief medical director in its Department of Medicine and Surgery.

Doctor Musser was director of professional services at Houston VA Hospital and professor of medicine at Baylor University College of Medicine when he was called to Washington in October 1959 to become assistant chief medical director for research and education in medicine.

A native of Terre Haute, Ind., he received both his B.A. and M.D. degrees from the University of Wisconsin. He served with the Army from 1941 to 1945 as commander for the 135th Medical Group, attaining the rank of colonel.

He succeeds Dr. H. Martin Engle, who will become director of the VA Center in Los Angeles. Dr. Benjamin B. Wells, at present director of the Cleveland VA Hospital, will succeed Doctor Musser by returning to his former post as head of medical research and education.

Dr. Rowe Wins U.W. Award

Dr. George G. Rowe, associate professor of medicine at the University of Wisconsin, was awarded the $1,000 medical alumni award for distinguished teaching during the Medical School's annual field day. To Dr. Julius J. Chosy went the $250 Inbusch award for meritorious medical research.

European Tour for Dr. Krohn

Dr. and Mrs. *Robert Krohn* were expected to return to Black River Falls May 27 following a European tour arranged by the International College of Surgeons. Several hundred doctors and their wives participated in the tour, which began with three days at English medical centers and ended in Paris after meetings in Vienna, Innsbruck, Salzburg, Munich, four medical centers in Switzerland, and Nancy, France.

Mental Health Group Hears Dr. Tenney

Dr. H. Kent Tenney, retired Madison pediatrician who has been called "the Dr. Spock of the Midwest," chose the subject, "Mental Health Begins with Children," for his talk before a public meeting sponsored in May by the Wood County Association for Mental Health.

Emergency Childbirth Topic of Dr. Batzner

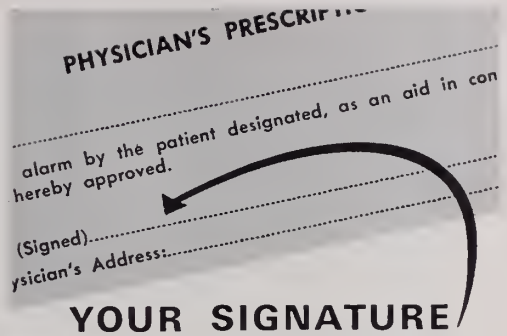
Dr. David J. Batzner, Sheboygan obstetrician, presented a discussion of emergency childbirth at the Sheboygan Vocational School in May in the last of a series on medical self-help arranged by the county civil defense office.

Tomah Doctor Presents Medicare Program

Dr. G. A. Landmann presented a movie and program on the subject of medicare at the monthly meeting of the Tomah P.T.A. in May.

Church Mental Health Group Hears Dr. O'Connor

Development of children between ages 6 and 12 was the topic of *Dr. Robert E. O'Connor,* of the Diagnostic Center, Madison, when he addressed the mental health group of the Orchard Ridge United Church of Christ.



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OBITUARIES

Doctor Branko Radich, Oshkosh, died July 30, 1963, at the age of 51.

He was graduated from the University of Medicine located at Milan and Bologna, Italy. After serving his internship in Italy, Doctor Radich practiced there until coming to this country in 1952. He served his residency at Medfield State Hospital, Medfield, Mass., and practiced in Connecticut prior to moving to Oshkosh in 1962.

He is survived by his widow, Stefania; one daughter, Erika Maria, and two sons, Paul and Steven.

Dr. George W. Bartels, 66, Janesville, died Oct. 21, 1963.

Originally from Manson, Ia., Doctor Bartels received his medical degree from the University of Iowa in 1926. He served his internship and residency at Lakeside Hospital, Cleveland, O., University Hospital, Iowa City, Ia., and University of Louisville Hospital, Louisville, Ky. Doctor Bartels had practiced in Janesville since 1930 except for the years he was in military service during World War II.

He was a member of the American College of Surgeons, the American Association of Railway Surgeons, the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Winifred; a son, John K., Denver, Colo.; and a daughter, Mary F., also of Denver.

Dr. Leonard S. Shemanski, Wautoma, died Nov. 9, 1963, at the age of 56.

Born in Menasha, Doctor Shemanski was a 1934 graduate of the Marquette University School of Medicine. He interned and served his residency at Milwaukee County General Hospital from 1933 to 1937, coming to Menasha that year to begin medical practice until his induction into military service in 1941. After his discharge in 1945, he returned to Menasha for two years before moving to Wild Rose where he practiced medicine until he moved to Wautoma in 1951.

Doctor Shemanski was a member of the Green Lake–Waushara County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Frances; two daughters, Sarah and Mary, both of Wautoma; five sons, ASC Frank John of Hahn Air Force Base, Germany; and Stephen, Ralph, Stanley, and Mark, all at home.

Dr. James T. Pauly, 44, La Crosse, died Dec. 25, 1963.

Originally from Dubuque, Ia., Doctor Pauly was a 1944 graduate of the University of Iowa College of Medicine, Iowa City. He interned at St. Francis Hospital, La Crosse, and served his residency at University Hospital, Iowa City, Ia. He practiced in Dubuque, Ia., before returning to La Crosse in 1949.

He was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, and seven children.

Dr. Hans W. Hefke, 66, chief of the Department of Radiology at Milwaukee Hospital, died Dec. 29, 1963.

Born in Kaltenkerchen, Germany, Doctor Hefke received his medical education at the University of Hamburg in 1923. He interned in Hamburg, Germany, and Milwaukee and served his residency at the Mayo Clinic, Rochester, Minn.

He was a fellow in the American College of Radiology, a member of the Radiological Society of North America, the Milwaukee Roentgenology Society, the Wisconsin Radiological Society, the Milwaukee Academy of Medicine, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Hefke was actively interested in private and civic music circles. He was a member of the Civic Music Association, a director of the Wisconsin College of Music and a patron member of the Chicago Symphony Association of Milwaukee, Inc.

Survivors include his widow, Helen; two sons, George W. of Salina, Kan., and Glen, New Orleans, La.

Dr. Robert C. Thompson, 63, St. Croix Falls, died Jan. 3, 1964.

A native of St. Croix Falls, Doctor Thompson was a graduate of the University of Minnesota Medical School in 1930 and located in Cumberland in 1931 where he practiced until 1956.

He was a member of the Barron–Washburn–Sawyer–Burnett County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Alberta; a daughter, Nancy of Minneapolis; and one son, Robert, Jr. of St. Paul Park.

Dr. Eugene F. Pischke, 43, Baraboo, died Jan. 7, 1964.

A native of Hayes, Kansas, Doctor Pischke was a graduate of the University of Nebraska College of Medicine in 1951. He served his internship at the Methodist Hospital, Omaha, Neb., and practiced in Nebraska before moving to Baraboo in 1954.

Doctor Pischke was a member of the Sauk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Ruth; three daughters, Ruth Marie, Christine, and Catherine; and one son, Steven, all of Baraboo.

Dr. Herman Decker, retired Milwaukee physician, died Jan. 18, 1964, at the age of 76.

He was graduated from the Milwaukee Medical College in 1901, and interned at Michael Reese Hospital. Doctor Decker has practiced in Milwaukee since that time except for the time he served in the Navy Medical Corps during World War I.

Doctor Decker was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow.

Dr. Henry Trautmann, former Madison physician, died Feb. 1, 1964, at the age of 73.

A native of Morrison, Doctor Trautmann was a 1916 graduate of the University of Virginia. Following internship at Orange Memorial Hospital, Orange, N. J., he practiced in New York State before coming to Madison in 1945. In 1960 Doctor Trautmann moved to Scottsville, Ariz.

Dr. O. Sidney Orth, world renowned anesthesiologist, Madison, died Feb. 2, 1964, at the age of 57.

Doctor Orth was born in Cincinnati, O. He received his bachelor's degree in athletic coaching in 1929 and his master's degree in physiology in 1932 from the University of Illinois and taught at Malden, Ill., and the University of Illinois before coming to Wisconsin in 1936, where he received a doctorate in physiology in 1939 and his M.D. degree in 1942. He was professor of pharmacology before becoming professor and director of the University of Wisconsin Anesthesiology Department in 1952.

Doctor Orth was widely known in the state as a rose grower and was a past president of the Madison Rose Society.

He was a member of the American Physiology Society, American Society of Pharmacology and Experimental Therapeutics, Society of Experimental Biology and Medicine, the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Therapeutic Society.

He is survived by his widow, Ottilia.

Doctor Robert H. Gray, a retired La Crosse physician, died Feb. 15, 1964, at Onalaska, at the age of 80.

A native of Apollo, Pa., Doctor Gray was a 1908 graduate of the Chicago College of Medicine and Surgery. He came to La Crosse in 1910 as a surgeon for the Burlington Railroad and later went into private practice.

During his years of practice, he was active in public health services. He assisted the county health nurse in her clinics and gave many hours of service to the bloodmobile unit. He was a member of the National Guard and served in France and Germany during World War I. Doctor Gray retired some 20 years ago.

In 1958 he became a member of the State Medical Society's Fifty-Year Club. In addition to the State Society membership, Doctor Gray was a member and past president of the La Crosse County Medical Society, and a member of the American Medical Association.

He is survived by his widow, Norma; a daughter, Mrs. J. W. Craighead of Denver, Colo.; two sons, Robert R. of Aurora, Ill.; and David S. of Minneapolis, Minn.

Dr. Carl A. Hultman, former Milwaukee obstetrician and gynecologist, died Feb. 17, 1964, at the age of 47, at Helena, Mont.

A native of Milwaukee, Doctor Hultman was a 1943 graduate of the Marquette University School of Medicine. He interned at Columbia Hospital and completed his residency at Milwaukee Maternity in 1949 at which time he established his practice in that city. Doctor Hultman had been director of Child Health Services for the State of Montana since September 1962. He served two years in the Army and Medical Corps in World War II.

He was a member of the American Academy of Obstetricians and Gynecologists, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Marian; three daughters, Charlotte, Marjorie, and Flicka; and a son, Carl, Jr.

Dr. Leslie G. Langlois, Milwaukee, died Feb. 26, 1964, at the age of 38.

A native of Milwaukee, Doctor Langlois was a 1957 graduate of the University of Wisconsin Medical School. He interned at Long Island College Hospital, Brooklyn, N. Y. and served his residency at Connecticut State Hospital, Middletown, Conn. and Hillside Hospital, Glen Oaks, N. Y. He served as captain in the Air Force during 1961.

Doctor Langlois was a member of the American Psychiatric Association, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow and a son.

Dr. Dexter H. Witte, a prominent Milwaukee surgeon, died Feb. 27, 1964, at the age of 75.

Born in Waukesha County, Doctor Witte was a 1916 graduate of the Marquette University School of Medicine and interned at Milwaukee County Hospital. During World War I, Doctor Witte served in the Army Medical Corps. He entered private practice in Milwaukee in 1919.

A member of the State Medical Society's original Committee on Medical Extension, Doctor Witte was instrumental in founding Surgical Care-Blue Shield. Doctor Witte was Chief of Staff and Chief of General Surgery at St. Mary's Hospital, Milwaukee, several times during his career.

He was a former president of the Medical Society of Milwaukee County, councilor of the State Medical Society of Wisconsin, and delegate to the American Medical Association. Doctor Witte was a founder of the Wisconsin Surgical Society and a member of the American College of Surgeons and the Milwaukee Academy of Medicine.

Surviving are his widow, Margaret; a son, Dexter, of Winchester, Mass.; and two daughters, Mrs. Charles C. Brooks, Atlanta, Ga. and Mrs. Luke Kauth, West Bend.

Dr. Thurman Earl Kendall, formerly of Wauwatosa, died Mar. 11, 1964, in St. Louis, Mo., at the age of 49.

Doctor Kendall received his medical degree from St. Louis University in 1940 and was a physician at St. Mary's Hospital, Racine, when he was called into service in 1941. After five years as captain in the Medical Corps he engaged in practice in Wauwatosa.

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This symbol has been freely offered by the A.M.A. to manufacturers and distributors of emergency medical signal devices and the publishers of medical identification cards. Thirty corporations and associations have adopted the universal symbol for use on their identifications and the number is increasing continuously. The A.M.A. neither manufactures nor distributes signal devices.

Many signal devices of metal or plastic will bear this symbol on one side with a few words of vital information on the other. Other devices will have a pocket within which more detailed information can be found. Still others may consist of the symbol alone—a suggestion to look elsewhere in purse or pocket for important information or identification.

Fix this symbol in your memory—the star of life (or the asterisk of reference), bearing the snake entwined staff of Aesculapius—taken from the seal of the American Medical Association, and all contained in a hexagon. This symbol may appear in any size or color. It is most likely to be found on the wrist or about the neck, though it may identify the presence of information in other locations.

Recognizing it as the universal symbol of emergency medical identification will help you to locate information that may protect life in an emergency.

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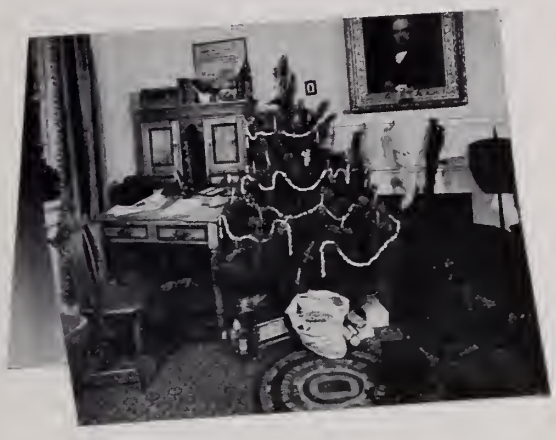

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1964 **Wisconsin**

Sept. 12–13: Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology, in conjunction with Wisconsin Otolaryngological Society, Maxwelton Bracs, Bailey's Harbor.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

Oct. 15–17: American College of Obstetricians and Gynecologists, District VI meeting, Milwaukee.

Nov. 14: Wisconsin Society of Pathologists, annual fall meeting, Marquette University School of Medicine, Milwaukee.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

1964 **Out-of-State**

Aug. 24–27: American Hospital Association, Chicago.

Aug. 24–28: International Conference on Preventive Cardiology, University of Vermont, Burlington, Vt.

Aug. 25–28: 17th annual meeting of American Association of Blood Banks, Shoreham Hotel, Washington, D. C.

Aug. 29–30: Annual meeting of executive committee and board of directors, American Society of Anesthesiologists, Chicago.

Sept. 9–11: 29th annual congress, International College of Surgeons, North American Federation, Chicago.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 17–19: Fifth National Cancer Conference, Philadelphia, Pa.

Sept. 20–26: III World Congress of Anesthesiology-World Federation of Societies of Anesthesiologists, Sao Paulo, Brazil.

Sept. 21–23: Annual continuation course of the Department of Pediatrics, University of Minnesota, Minneapolis.

Sept. 21–25: Animal Care Panel, 15th annual meeting, Hilton Hotel, New York City.

Sept. 24–26: American College of Chest Physicians, postgraduate course in electrocardiography in infants and children, Henry Ford Hospital, Detroit.

Sept. 24–26: American College of Obstetricians and Gynecologists, District VIII, Del Coronado Hotel, San Diego, Calif.

Sept. 25–27: ACOG, District II, Hotel Concord, Lake Kiamesha, N. Y.

Sept. 28–30: American College of Chest Physicians, postgraduate course in environmental diseases of the heart and lungs, Pick–Carter Hotel, Cleveland.

Sept. 30–Oct. 2: Florida Diabetes Association, Seminar on diabetes and related endocrine disorders, Balmoral Hotel, Miami Beach, Fla.

Oct. 5–7: University of Colorado School of Medicine, postgraduate course in fractures and dislocations, University of Colorado Medical Center, Denver.

Oct. 1964–Mar. 1965: Biweekly courses in Continuing Education Program in Psychiatry and Psychotherapy, Mount Sinai Hospital, Chicago, Ill.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 21–22: 18th annual meeting of Council on Arteriosclerosis, American Heart Association, Hotel Shelburne, Atlantic City, N. J.

Oct. 22–24: American College of Gastroenterology annual course in postgraduate gastroenterology, The Roosevelt, New York City.

Oct. 23–25: American Heart Association 37th annual scientific sessions, Convention Hall, Atlantic City, N. J.

Oct. 26–29: National Safety Congress, Chicago.

Oct. 26–30: American College of Chest Physicians, postgraduate course in clinical cardiopulmonary physiology, Continental Hotel, Chicago.

Nov. 3–7: American Society of Oral Surgeons, 46th annual meeting, Las Vegas, Nev.

Nov. 7–8: National conference on disaster medical care, Chicago.

Nov. 13–16: 1964 annual convention of National Society for Crippled Children and Adults, Statler–Hilton Hotel, Detroit, Mich.

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–18: Section on Otolaryngology of the Southern Medical Association annual meeting, Memphis, Tenn.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

1965

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

1966

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Mount Sinai Course in Psychotherapy

The Department of Neuropsychiatry, Mount Sinai Hospital, Chicago, Ill., announces its 1964–1965 Continuing Education Program in Psychiatry and Psychotherapy for physicians and those in professions related to psychiatry. These courses will be held biweekly from October 1964 through March 1965 under the direction of H. H. Garner, M.D.

Registration will be limited to 25 physicians who will receive instruction by patient demonstration and didactic lectures. The American Academy of General Practice offers Category No. 1 credit for some of these courses.

Interested registrants should write directly to the Department of Neuropsychiatry, L 206, Mount Sinai Hospital, 1755 W. 15th Street, Chicago, Ill. 60608.

American College of Chest Physicians

Physicians from more than 50 countries will present papers and discuss the recent advances in cardiovascular and pulmonary diseases at the VIII International Congress on Diseases of the Chest to be held in Mexico City, October 11–15. All physicians are invited to attend this important Congress. For further information and registration blanks write to the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

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AABB 17th Annual Meeting

Dr. G. C. Liggins of Auckland, New Zealand, who helped pioneer the development of amniocentesis as a guide to therapy for women isoimmunized to the Rh factor, will be a featured guest at the 17th annual meeting of the American Association of Blood Banks Aug. 25–28 at the Shoreham Hotel in Washington, D.C. About 2,000 delegates and guests will attend.

The annual meeting will convene Aug. 25 with an all-day technical seminar on blood component therapy. Subsequent sessions will be devoted to papers and panel discussions on many other facets of blood banking and hematology.

When the AABB annual meeting adjourns, many delegates will board a charter flight to Stockholm, Sweden, to attend biennial congresses of the International Society of Hematology and the International Transfusion Society.

UM Pediatrics Department Course

The annual continuation course of the Department of Pediatrics, University of Minnesota, titled "The Health of the Child and the Physician (Some Keys to Implementation)," will be presented Sept. 21 to 23. Requests for further information may be directed to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial (Box 193), University of Minnesota, Minneapolis, Minn. 55455.

Chicago Disaster Plan Scheduled

How a major metropolitan complex makes plans and implements those plans for disasters will be presented at the National Conference on Disaster Medical Care scheduled for Nov. 7–8 in Chicago.

Speakers will include: Chief Curtis Volkamer, director of training at the Chicago Fire Academy, who will present the plan; Dr. Harold P. Sullivan, chief surgeon of the fire department, who will talk on the medical aspects of disaster at the site; Dr. J. D. Farrington, chairman, Chicago committee on trauma, American College of Surgeons, who will discuss the training provided firemen in the immediate care of the sick and injured; and Dr. James E. Segraves, chairman of the disaster committee, St. Anne's Hospital, Chicago, who will discuss the handling of casualties at two actual disasters.

Additional information and advance registration may be obtained by writing to the Council on National Security, 535 N. Dearborn Street, Chicago, Ill. 60610.

American Thoracic Society

The annual meeting of the American Thoracic Society, medical section of the National Tuberculosis Association, will be held in Chicago May 31 to June 2, 1965.

Papers to be presented will be selected from abstracts submitted before Jan. 6, 1965, to the chairman of the medical sessions committee, which invites submission of papers on all scientific aspects of tuberculosis and nontuberculous respiratory and cardio-pulmonary diseases. Membership in the society is not a prerequisite to participation on the program.

Further information concerning the submission of abstracts may be obtained by writing Benjamin Burrows, M.D., Chairman, Medical Sessions Committee, American Thoracic Society, 1790 Broadway, New York 19, N.Y.

AHA Scientific Sessions

The 37th annual scientific sessions of the American Heart Association will be held Oct. 23–25 in Convention Hall, Atlantic City, N.J.

Six clinical sessions of primary interest to the practicing physician will be held simultaneously with regular sessions and programs covering a broad range of cardiovascular research. The clinical programs include the presentation of original investigative work in addition to panels, lectures and symposiums. An all-day session on stroke on Oct. 24 will cover aspects of special interest to the general practitioner, from prevention through long-term convalescent care.

Immediately preceding the scientific sessions, the association's Council on Arteriosclerosis will hold its 18th annual meeting, Oct. 21–22, in Atlantic City's Hotel Shelburne.

Advance registration and hotel reservation forms may be obtained from the American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.

SECOND ANNUAL PRAIRIE DU CHIEN MEDICAL SEMINAR

The Crawford County Medical Society has announced the program for its Second Annual Prairie du Chien Medical Seminar on Thursday, Aug. 13.

Planned for the morning are nine holes of golf at the Prairie du Chien Golf and Country Club, and tours through the Museum of Medical Progress and Stovall Hall of Health. The afternoon will be devoted to a scientific meeting at the Metro Theater, where speakers will be Dr. Frank C. Stiles of the Monroe Clinic, "Childhood's Number One Killer," and Dr. Charles W. Crumpton of the University of Wisconsin Medical School, "Therapy of Heart Disease."

For the physicians' wives, a tea and introduction period has been planned from 1 to 2 p.m., followed by tours of the Medical Museum, Stovall Hall of Health, the Villa Louis, and/or bridge.

At 5 p.m., the doctors will join their wives for a two-hour cruise along the Mississippi to Indian Isle and a 7 o'clock dinner there. The $5.00 fee per person applies only to those who wish to participate in the river trip and dinner.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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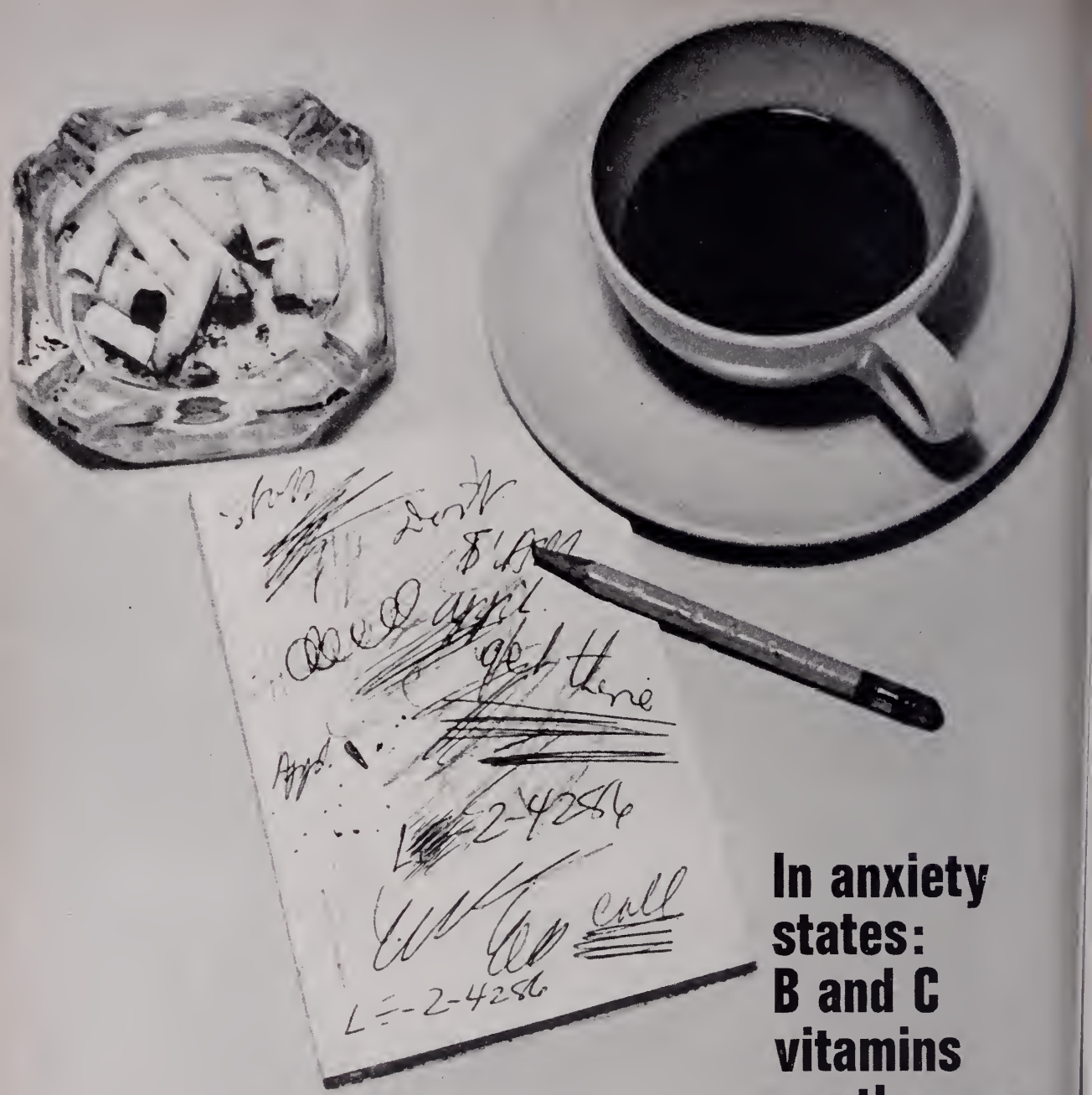
Journal
Established 1903
Annual Subscription ------$6.00
Single Copy ---------- 1.00
Previous Years' ---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.



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LETTERS

NURSING LIAISON ACTIVITIES IN STATE MEDICAL SOCIETIES

To WMJ:

We believe you may be interested in reading the enclosed Committee on Nursing report, recently published in JAMA (May 18, 1964), entitled "Nursing Liaison Activities in State Medical Societies".

This article presents a brief summary of the findings of a questionnaire survey designed to determine the current status of nursing liaison activities within state medical societies. The Committee on Nursing is hopeful that this study and its findings will not only provide a stimulus to local committees to expand and strengthen their nursing liaison activities but also encourage the initiation of new programs in those states where no liaison presently exists.

FLORENCE M. ALEXANDER, R.N., Ph.D.
Director
Division of Scientific Activities
Department of Nursing
American Medical Association

THEY LIKED THE MUSEUM

To MUSEUM CURATOR:

On behalf of Girl Scout Troop 53 of Blessed Sacrament School (La Crosse), the chaperones, and myself, I wish to express my gratitude for all the courtesies extended our group on our visit to the museum on May 7. You are doing a terrific job. The innovations made since last year are tremendous. "Hats off" to you and your staff.

MRS. ROBERT G. SCHAEFER
La Crosse

To MUSEUM CURATOR:

We would just like to extend a very hearty thank you to you and your staff for the hospitality and effort put forth by you during our recent visit. The group had nothing but compliments for the welcome received. We are all looking forward to returning again. We feel that the job that you are doing is a tremendous asset to the teaching of science in this area.

DARREL HOFF, Head
Science Department
Westby High School
Westby

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin, 53701.*

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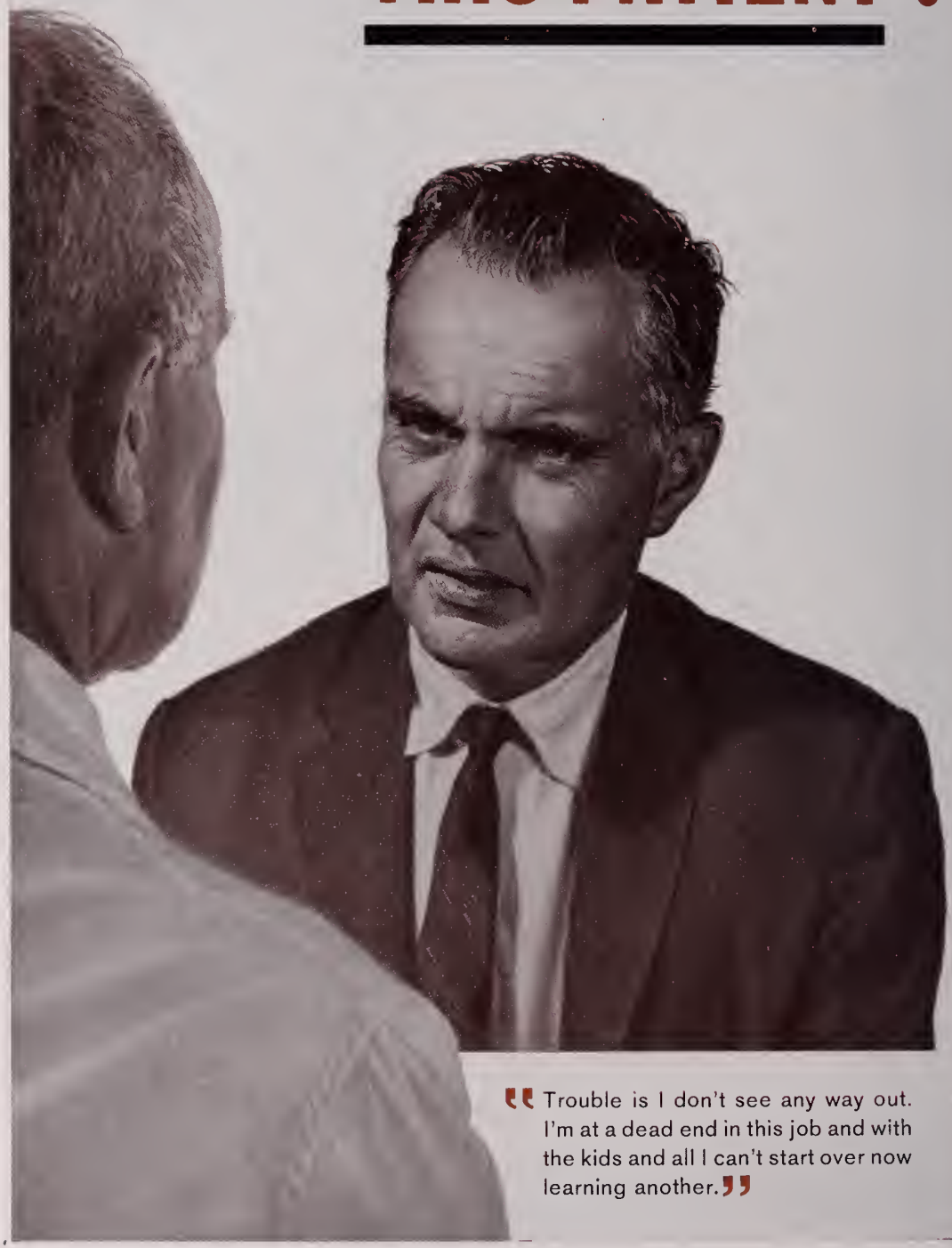

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WHAT IS A COUNTY ADVISORY COMMITTEE?

A County Advisory Committee is oppointed by the president of the county medical society ond meets periodicolly to review cloims (less thon one percent of total claim volume) referred to the committee by the WPS cloims department.

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This procedure places the responsibility and the authority for determining fees where it belongs . . . with the local physicion.

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COUNTY SOCIETY PROCEEDINGS

CHIPPEWA

The Chippewa County Medical Society planned and organized the first annual banquet of three of Chippewa county's professional organizations: the medical society, the dental society, and the bar association. The party, with wives invited, was held at the Elks Club in Chippewa Falls.

Officers of the Chippewa County Medical Society are *Dr. Charles A. Kemper*, president, and *Dr. James L. Windeck*, secretary-treasurer. The committee for instituting the banquet included Doctor Windeck, chairman; *Dr. Diane Dahl* and *Dr. J. J. Sazama*. All are from Chippewa Falls.

Dr. C. B. Hatleberg, Chippewa Falls, was one of the "senior citizens" who offered after-dinner comments. Featured speaker was *Dr. J. B. Dibble*, Eau Claire, who with his family recently returned from Africa where he served as a surgeon for a mission hospital. He and his wife showed films and slides of two native tribes with whom they were associated, and also played tape recordings made of the natives.

DANE

NEEDY DANE COUNTY students will be able to obtain financial assistance to complete their education in a health field due to the surplus money accumulated as a result of the recent Dane County "S.O.S." polio program. A loan fund to be administered by the Charitable, Educational and Scientific Foundation of the State Medical Society has been established for needy Dane County students studying in medicine, nursing, dentistry or pharmacy. *Dr. P. R. Kundert* (left), president of the Dane County Medical Society, is shown presenting the check for $29,126.04 to *Dr. W. D. Stovall*, president of the Foundation. Looking on in the background from left to right are *Dr. W. H. Ylitalo*, co-chairman, D. R. Pozynski, coordinator, and *Dr. W. H. Bartlett*, chairman of the program.

The Dane County Medical Society will hold its annual golf tournament September 22 at Nakoma Country Club.

Physicians whose names appear in italics are members of the State Medical Society.

GREEN

Dr. John Irvin, Monroe, is the 1964 president of the Green County Medical Society. Recently accepted into membership in the society was *Dr. S. Q. Jew*, Monroe, neurologist.

Members of the committee for the county-wide Sabin polio vaccine program which has now been completed in Green county included *Dr. Frank C. Stiles*, *Dr. E. A. Zupane*, and *Dr. Charles O. Miller* of Monroe, *Dr. William E. Hein* of Brodhead, and *Dr. Philipp H. Marty* of New Glarus.

LINCOLN

Under the sponsorship of the Lincoln County Medical Society, a county-wide tetanus education program has been underway in Lincoln County. The program has been endorsed by the Lincoln County Health Committee and the Merrill Board of Health.

OUTAGAMIE

Occupational therapy programs were the topic of discussion at a meeting of the Outagamie County Medical Society in June at St. Elizabeth Hospital in Appleton.

PIERCE–ST. CROIX

The May meeting of the Pierce–St. Croix County Medical Society was held jointly with pharmacists. Golf and refreshments were enjoyed by the two groups during the afternoon and evening at River Falls Country Club.

RACINE

The Racine County Medical Society held a picnic July 15 at Johnson's Park. The afternoon affair featured refreshments and food, pony rides, and games and prizes for the children. Picnic chairman was *Dr. Olli Kaarakka*, Racine.

Early in June, the Racine County Medical Society, together with the Racine Health Fund, member agency of Racine United Community Services, sponsored a 4-day Health-O-Rama at Memorial Hall, Racine. Several other organizations also cooperated in the family health fair, at which tests were given for a wide variety of diseases. Of the 25 displays, 18 were from the American Medical Association. Movies were shown continuously from an overhead

screen in the middle of the hall, and health records and pamphlets were given out. Conversation with personnel staffing the exhibits was encouraged.

The summer dinner-dance of the Racine County Medical Society was held June 13 at the Meadowbrook Town and Country Club.

The Lincoln Lutheran Home medical staff met with the Society in April, when the decision was reached to make the Society's president-elect president, also, of the Lutheran Home medical staff, with the current secretary likewise becoming the Home staff secretary.

The Society also decided to have one of its members join the Racine Chamber of Commerce, his appointment to be made by the president every two years. *Dr. Warren Williamson* is the current appointment of *Dr. Frank J. Scheible*, Society president.

Racine unions are probing the feasibility of a blood blank, and *Drs. Ernest S. Olson* and *Myron Schuster* have been appointed to a committee to offer supervisory as well as instructional help if such a program is necessary.

RICHLAND

A paper on "Maternal Mortality" was presented by *Dr. C. Weir Horswill*, Madison, at the June meeting of the Richland County Medical Society in the library of the Richland Center Hospital.

"Evaluation of Total Disability as re: Social Security Benefits" was the subject discussed at the society's May meeting. Speakers were *Dr. William P. Crowley, Jr.*, chief medical consultant for the State Division of Vocational Rehabilitation, Madison, and Perry D. Anderson, regional representative of the Social Security Administration, La Crosse.

SHEBOYGAN

A panel of physicians and other medical care representatives explained the features of the Kerr–Mills law at a public meeting sponsored by the Sheboygan County Medical Society June 24 at Turner Hall, Sheboygan. *Dr. Richard B. Windsor* of Sheboygan was chairman of the meeting.

TREMPEALEAU–JACKSON–BUFFALO

A scientific program was presented at the June 23 meeting of the Trempealeau–Jackson–Buffalo County Medical Society at the Mississippian in Buffalo City, one mile west of Cochrane.

Dr. David H. Corser, La Crosse pediatrician, addressed the meeting of the Society July 28 at Club Midway, Independence. His subject was "Behavior Patterns in Pediatric Practice." Wives of the members were invited to the meeting, for which Blair–Ettrick members were hosts.

WALWORTH

After reviewing clinic attendance at the county immunization programs, the Walworth County Medical Society has concluded that attendance of preschool children and infants was so small as to make it financially impractical to continue support of these clinics. As a result, the society has suggested that beginning this fall, the clinics in the schools will no longer include infants and preschool children. However, if obtaining needed immunization from family doctors would impose a financial hardship, the society has agreed that no one will be denied immunization because of financial inability to assume the cost.

WINNEBAGO

Dr. Charles C. Lobeck, associate professor of pediatrics at the University of Wisconsin Medical School, was guest speaker for the June meeting of the Winnebago County Medical Society. His topic was "Avoidable Problems in Fluid Management."

Dinner at the Oshkosh Country Club preceded the program, for which *Dr. Melvin G. Apell* of Oshkosh served as chairman.

HOUSE OF DELEGATES
Fall Session
State Medical Society Headquarters
October 9–10

MILWAUKEE MEDICAL CONFERENCE

Wednesday and Thursday, November 11–12
Milwaukee County Hospital

The Medical Society of Milwaukee County is sponsoring this fourth annual event in cooperation with other medical groups and Milwaukee area hospitals. Registration fee is $5.00. Inquiries should be addressed to: 1964 Milwaukee Medical Conference, The Medical Society of Milwaukee County, 756 N. Milwaukee St., Milwaukee, Wis. 53202. Further details can be found in the MEDICAL MEETINGS section of this issue.

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Heart Association–County Societies Sponsor Clinics

Young patients referred by local physicians were examined by *Dr. Fred Fletcher*, internist at the Marshfield Clinic, and *Dr. Richard Sautter*, clinic surgeon, April 30 when the Wisconsin Heart Association and the Vernon County Medical Society held a congenital and rheumatic heart disease clinic at the Vernon Memorial Hospital in Viroqua.

A similar clinic, sponsored by the heart association and the Green Lake–Waushara County Medical Society, was conducted at the Memorial Hospital in Berlin. *Drs. Richard H. Wasserburger* and Thomas C. Meyer of Madison examined patients referred to the clinic by their physicians.

St. Mary's Hospital in Sparta was the site for a third clinic at which two Madison physicians, *Drs. Anthony J. Richtsmeier*, internist, and *Horace K. Tenney, III*, assistant professor of pediatrics at the University of Wisconsin Medical School, examined persons up to age 20 suspected of having congenital and rheumatic heart disease. Clinic co-sponsors were the heart association and the Monroe County Medical Society.

Dr. William H. Ylitalo, Madison pediatrician, and Dr. Robert J. Corliss, cardiologist at the Madison VA Hospital, were the examining physicians at the clinic sponsored by the heart association and the Price–Taylor County Medical Society at the Medford Clinic.

Dr. William Smiles, internist-preceptor with the Smiles–Prentice medical group at Ashland, and *Dr. W. K. Simmons*, Rhinelander, internist and preceptor with the Bump medical group, are directors of the Wisconsin Heart Association, which sponsored a one-day clinic at St. Mary's Hospital, Superior, with the approval of the Douglas County Medical Society.

The clinic at Langlade Memorial Hospital, Antigo, was co-sponsored by the heart association and the Langlade and Lincoln County Medical Societies. *Drs. Thomas R. Leicht*, Green Bay internist, and *Sherburne F. Morgan*, Milwaukee pediatrician, examined about 25 patients.

Dr. *William J. Gallen*, pediatrician at Milwaukee Children's Hospital, and *Dr. John K. Olinger*, Milwaukee internist, also examined about 25 patients during the clinic held at Calumet Memorial Hospital in Chilton under the auspices of the heart association and the Calumet Medical Society.

Dr. John H. Wishart, Eau Claire internist, and *Dr. H. D. Nester*, Eau Claire pediatrician, were the examining physicians at a congenital and rheumatic heart disease clinic held at Park Falls Memorial Hospital under the sponsorship of the Wisconsin Heart Association and the Price–Taylor County Medical Society.

Lakeside Methodist Hospital in Rice Lake was the scene of another clinic, held under the auspices of the heart association and the Barron–Washburn–Sawyer–Burnett County Medical Society. Some 25 patients were examined by *Drs. D. A. Emanuel* and *George G. Griese*. Doctor Emanuel is an internist at the Marshfield Clinic, where Doctor Griese is a pediatrician.

The clinics were a few of many held in Wisconsin this spring and early summer, financed with funds donated during the Heart Fund Drive.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Fond du Lac County Medical Assistants

Fond du Lac County Medical Assistants heard *Dr. William Funcke*, Beaver Dam, review the Dodge County Civil Defense program when they met at the Fond du Lac Clinic.

A report was given on the Dodge County meeting in Beaver Dam, where Miss Alice Budny, immediate past president of the American Association of Medical Assistants, discussed on-the-job study for certification.

Milwaukee Academy Holds Renal Disease Symposium

A symposium on chronic renal disease was held by the Milwaukee Academy of Medicine May 19 at the University Club of Milwaukee. Speakers were Drs. Neal S. Bricker, associate professor of internal medicine at Washington University School of Medicine, St. Louis, whose subject of discussion was "Functional Aspects of the Chronically Diseased Kidney;" George E. Schreiner, associate professor of medicine, renal and electrolyte division, Georgetown University Hospital, Washington, D.C., "Uremia;" and Benjamin H. Spargo, associate professor of pathology, University of Chicago, "Role of Biopsy in the Diagnosis and Understanding of Disease Processes." The three also conducted a "Wet Clinic" at Milwaukee County Hospital on May 20, following which they discussed "The Nephrotic Syndrome" at Medical-Surgical Grand Rounds. Co-sponsoring the program were the academy and the National Kidney Disease Foundation.

Milwaukee Gynecological Society Elects

At the annual meeting of the Milwaukee Gynecological Society at the University Club of Milwaukee, the following officers were elected: *Dr. Jack A. Klieger*, president; *Dr. William P. Wendt*, vice-president; *Dr. Saul F. Schwartz*, secretary-treasurer (two-year term).

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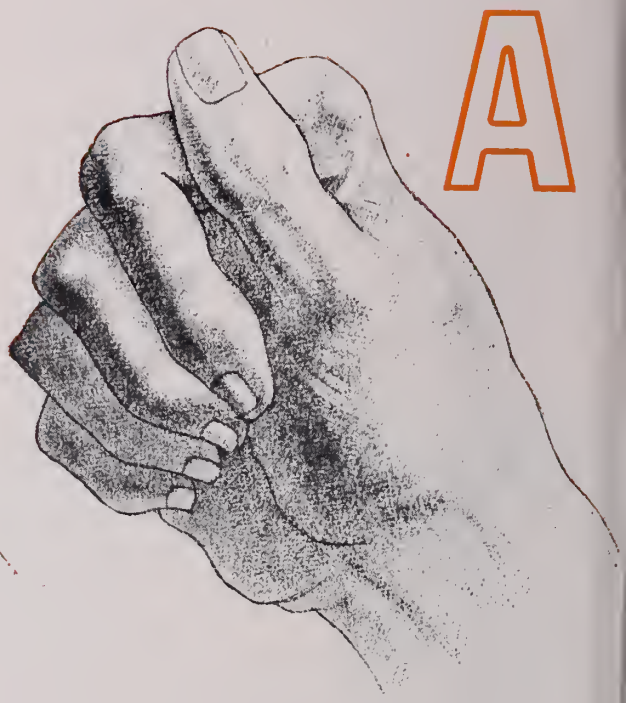


ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which necessitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

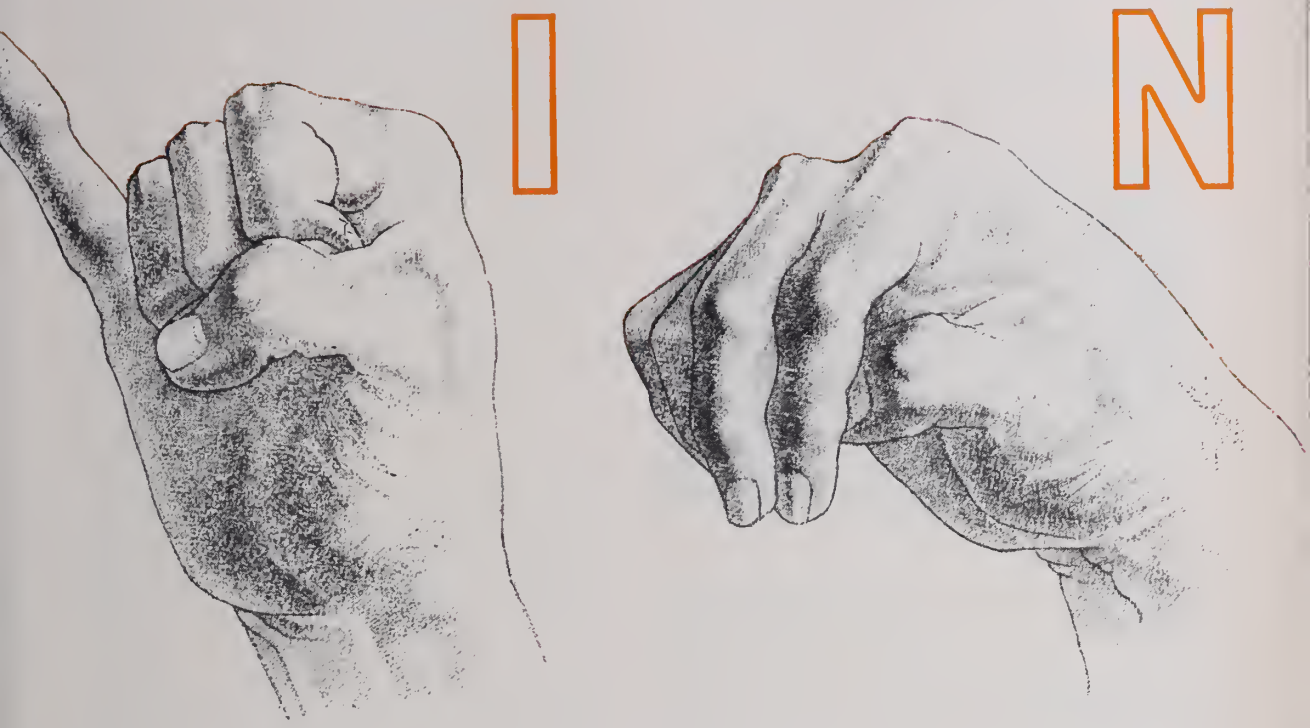
Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

The basic Arthralgen formulation plus prednisone is indicated for patients who require steroids. Prednisone has three advantages over cortisone, hydrocortisone, and ACTH. They are: (1) lack of sodium retention, (2) absence of increased potassium excretion, and (3) the unlikelihood of steroid induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acut

arthritic joints from



gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms, dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

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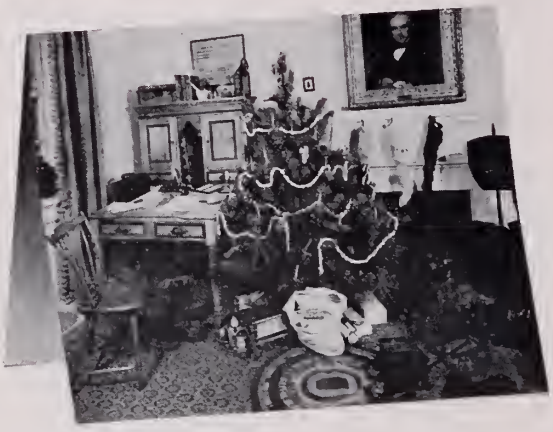

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SPECIALTY PROCEEDINGS *continued*

Dr. Sosman to Head State Chapter of ACCP

Dr. A. J. Sosman, Milwaukee, was elected president of the Wisconsin chapter, American College of Chest Physicians, at the organization's annual meeting in May. Other officers elected for the forthcoming year were *Dr. E. O. Henschel* of Wood, vice-president; and *Dr. S. T. Gettelman*, West Allis, secretary-treasurer. *Dr. Edgar End* of Milwaukee discussed "The Hyperbaric Chamber and Its Uses."

Milwaukee WPA Elects Officers

Dr. Jack Coheen was elected president of the Milwaukee branch, Wisconsin Psychiatric Association, at its last regular meeting of the year June 3 at the University Club, Milwaukee. Elected with Doctor Coheen were *Dr. Jack Geist*, president-elect; *Dr. H. Gladys Spear*, secretary; Dr. Robert Weber, treasurer; and for the council, *Drs. E. T. Sheehan, Owen Otto* and *B. Cullen Burris. Dr. Charles Landis*, Milwaukee County director of mental health and past president of the W.P.A., discussed the past, present and future of psychiatry in Milwaukee County.

Annual Meeting of State Medical Assistants

Election and installation of officers was a feature of the 10th annual meeting of the Wisconsin State Medical Assistants Society June 5–7 in Racine. Mrs. Aleen Piepenburg of Waukesha was installed as state president, with Miss Alice Roelse of Port Washington designated president-elect; Miss Judith Kerl, Milwaukee, recording secretary; and Jeanne Jackson, Milwaukee, treasurer.

Speakers included *Dr. George E. Collentine, Jr.*, Milwaukee, whose topic was "The Role of Government in Health Care of the People;" and *Dr. A. Yale Gerol*, Kenosha, "Nostrums, Notions and Potions." At the opening session of the three-day meeting, welcoming addresses were given by Miss Edith C. Murphy, Milwaukee, outgoing president; *Dr. Frank J. Scheible*, president of the Racine County Medical Society, and Mayor William H. Beyer, Racine.

Wisconsin–Upper Michigan Group Meets

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology held a postgraduate program June 6 and 7 at the Avalon Hotel in Waukesha. *Dr. Robert T. Schmidt* of Green Bay is president of the society and *Dr. G. L. McCormick* of Waukesha is its secretary. Social events during the program included a tea for the ladies at the residence of *Dr.* and Mrs. *James V. Bolger, Jr.*, Woods road, and dinner the evening of June 6 at the hotel.

Kenosha Psychiatrist Cites Local Needs

Certain needs in the Kenosha community are not being met, *Dr. George R. Weber*, Kenosha psychiatrist, told members and guests of the Family Counseling Center at a dinner celebrating the center's second birthday.

Three vital and immediate needs he listed as: (1) A full-time psychiatric social worker to assist the courts in their disposal of patients; (2) a halfway house where discharged mental patients can learn to adjust back to the community; (3) an active treatment center for the alcoholic patient.

Plastic Surgery Board Certifies Dr. Demergian

Dr. Vaughn Demergian, of the staff of the Jackson Clinic, Madison, has recently been certified a diplomate by the American Board of Plastic and Reconstructive Surgery.

Nurses Hear Dr. Chancey

Dr. Robert L. Chancey of the Beloit Clinic discussed "Pulse of Life and CCR Demonstration" when he addressed the nurses' program of the Wisconsin Heart Association's 16th annual meeting and scientific sessions on June 13 at the Wisconsin Center, Madison. He was one of three guest speakers for the program.

Dr. Hodges Addresses Pharmacists

Dr. Paul C. Hodges, Jr., Appleton, spoke on "The Role of the Pharmacist in the Detection of Early Cancer" at the Outagamie County Pharmaceutical Association meeting late in May.

Dr. Miller Is 94

Dr. E. A. Miller, left, of Clintonville was 94 years old on April 12. He retired from a long and active career in medicine in 1960 after 64 years of practice. He was graduated from Rush Medical College, Chicago, and started his practice in Clintonville in 1896.

Photo courtesy
APPLETON POST–CRESCENT

Prospective Medical Students Hear Milwaukee Physicians

Three Milwaukee physicians addressed prospective medical students at the 12th annual career guidance day sponsored by Marquette's chapter of the Student American Medical Association. *Dr. Chesley P. Erwin*, Milwaukee, spoke on pathology of the lung; *Dr. J. J. Jacoby*, of Milwaukee County Hospital, on anesthesia; and *Dr. William W. Stead*, on lung diagnosis.

Physicians whose names appear in italics are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Power Mower Hazards Discussed by Dr. Sullivan

Dr. John T. Sullivan, Jr., Milwaukee, spoke on the hazards of power mowers and rules of safety in their use at a meeting of the Milwaukee County Association of Medical Record Librarians.

Dr. Smith Accepts Radiologist Appointment

Dr. Robert L. Smith, former head of the department of radiology at a Sheridan, Wyo., hospital, has moved, with his wife and three children, to the Lakeland area where he has been appointed as radiologist at Lakeland Memorial Hospital in Woodruff. He will also serve Park Falls Memorial Hospital.

A 1951 graduate of the Marquette University School of Medicine, Doctor Smith was with the Marshfield Clinic for three years following an equal number of years of residency in radiology at Milwaukee County General Hospital. He went to Sheridan Memorial Hospital in 1959. He is certified by the American Board of Radiology and is a member of the American College of Radiology and the Radiology Society of North America, as well as the American Medical Association.

Hospital Pharmacists Hear Dr. Shahrokh

Dr. Darius K. Shahrokh, otolaryngologist at Fond du Lac Clinic, was guest speaker at the meeting of the Wisconsin Society of Hospital Pharmacists in May at Fond du Lac. He presented a lecture on "Medical and Surgical Treatment for Deafness."

Jackson Clinic Reelects Staff

The following officers were recently reelected for 1964 at the Jackson Clinic, Madison; *Dr. Luther E. Holmgren*, president; *Dr. Hubert C. Ashman*, vice-president; *Dr. John J. Mueller*, secretary; and *Dr. Howard W. Mahaffey*, treasurer.

Dr. Shannon to Head 'Y' in Wausau

Dr. Richard C. Shannon, Wausau surgeon, was chosen to succeed Carl Ziebell as president of the Woodson YMCA at the annual report meeting in May at the Wausau YMCA building. As new president, he will direct the expanding membership and association plans, programs and problems of the Woodson 'Y', which in the past year has achieved a membership of 5,151.

Dr. Macgregor Backs Mental Health Study

A county mental health study committee was approved in a 43–2 vote of Columbia County Board members in May. *Dr. James Macgregor*, Portage, medical adviser to the board's health and education committee, was among those who appeared to support Miss Sonya Smith, RN, county health nurse, in requesting the study to establish how many young people and adults in the county need outpatient mental health services, and to recommend a program to provide the services.

"I want to assure you the physicians in the county are behind this study 100 per cent," Doctor Macgregor stated.

To finance it, a $1,000 transfer of proceeds from the county oral polio vaccine clinic was voted 37–6 by the board.

Dr. Fruchtman Relocates Offices

Dr. Martin Fruchtman has relocated his offices for the practice of internal medicine and allergy at 217 Wisconsin Avenue, Waukesha. His former address was 324 West Main Street, Waukesha.

Dr. Puchner Addresses TOPS

Dr. Thomas C. Puchner discussed "Diet and Heart Disease" when he addressed the June 8 meeting of the TOPS organization at 3806 West Burleigh St., Milwaukee. Doctor Puchner, a Milwaukee cardiologist, appeared through Wisconsin Heart Association sponsorship. He is a very active member of the Wisconsin Heart Association, Milwaukee County Heart Unit, in which he is chairman of the Speakers Bureau and several other committees.

Heart Association Hears Dr. Killip

Dr. Thomas Killip III, assistant professor of medicine at the Cornell University Medical School, chose the topic, "Treatment of Cardiac Arrhythmias by Synchronized Pre-cardial Shock," for his appearance as one of the guest speakers at the Wisconsin Heart Association's 16th annual meeting and scientific sessions May 23 at the University of Wisconsin's Wisconsin Center.

Dr. Marsho Is Memorial Day Speaker

Dr. Bernard Marsho, Sheboygan physician and surgeon and a World War II Medical Corps veteran, was the main speaker at the Memorial Day program honoring Sheboygan area's war dead. A 1943 graduate of Marquette University School of Medicine, Doctor Marsho has been practicing in Sheboygan since 1948. In 1943 he was called to active duty and commissioned a lieutenant junior grade in the U. S. Navy, in which he served until his discharge in 1947. The week preceding Memorial Day, Doctor Marsho was guest speaker at South High School's Awards for Service program at the school auditorium in Sheboygan.

Dr. Leonard Addresses West Rotary

"Archeology in Spain and Portugal" was the subject of *Dr. Thomas A. Leonard's* illustrated talk before the Madison West Rotary Club late in May.

Dinner Honors Dr. Curran

Dr. William P. Curran of Antigo, new president of the State Medical Society of Wisconsin, was honored at a testimonial dinner held at the Langlade County Memorial Hospital. Some 30 persons were present for the dinner, which was a highlight of Antigo's observance of National Hospital Week. Tribute to Doctor Curran was paid by *Dr. Dee Dailey*, Elcho, chief of the hospital medical staff. Guests included staff doctors and the board of advisers.

Marquette Names Dr. Annis "Alumnus of Year"

Alumnus of the year of Marquette University is Dr. Edward R. Annis of Miami, Fla., president of the American Medical Association, the World Medical Association, and a 1938 graduate of the Marquette School of Medicine. The honor was conferred at the university's commencement exercises June 7. *Dr. David J. Carlson*, Milwaukee, retiring alumni association president, read a citation.

Dr. Hugh Greeley Honored

Dr. Hugh Greeley, member of the staff of Madison General Hospital, was honored for his 50 years of membership in the Massachusetts Medical Society at the society's 183rd annual meeting in May at Boston. A former clinical professor of medicine at the University of Wisconsin Medical School, Doctor Greeley is a past president of the Dane County Medical Society, and a member of the State Medical Society of Wisconsin, the Massachusetts Medical Society, the American Geriatric Society, the American College of Physicians, the Wisconsin Heart Association, and the Wisconsin Heart Club.

Jackson Clinic Postgraduate Meeting

More than 50 physicians of Madison and the area attended the Jackson Clinic and Foundation's spring postgraduate meeting late in May at Madison.

Dr. Arnold S. Jackson extended the welcome, and meeting chairmen were *Drs. John H. Morledge* and *William B. Parsons, Jr.*

Speakers during the first part of the program were *Drs. David L. Williams*, obstetrician and gynecologist, whose theme was "Recognition and Management of Carcinoma of the Endometrium;" *Louis F. Warrick, Jr.*, internist, "Diagnostic Procedures in Thyroid Disease;" and *Klaus D. Backwinkel*, surgeon, "The Silent Gallstone."

Following intermission, *Dr. Albert V. Kanner*, ophthalmologist and guest speaker, discussed the subject, "To See or Not to See." Two internists, *Dr. William J. McAweeney* and Doctor Morledge, presented a discussion of "Life-Saving Measures in Apparent Cardiac Death or Life-Threatening Arrhythmia." Doctor McAweeney's topic was "What

Can Be Done at Home or in the Office?". Doctor Morledge spoke on "Use of Special Facilities at the Hospital. Special equipment was demonstrated.

Physicians attending came from Madison, Muscoda, Fennimore, Milwaukee, Edgerton, Hales Corners, Tomah, Dodgeville, Wisconsin Dells, Racine, Belleville, Fox Lake, Richland Center, Wauwatosa, Burlington, DeForest, Waupaca, Juneau, Deerfield, Ripon, Oregon, Mt. Horeb, Chilton, Waukesha, Janesville, Sun Prairie, Oshkosh, Darlington, Footville, Berlin, West Bend, Brodhead, Blanchardville, Waupun, and Verona, Wis., and Dixon, Freeport, Stockton, Savanna and Amboy, Ill.

Dr. Young Accepts California Post

Dr. Carol E. Young, a native of Oshkosh and graduate of the University of Wisconsin, has joined the San Bernardino Medical Group in San Bernardino, Calif., as a pediatrician. Doctor Young will also serve on the staff of three hospitals in that city. She took her premedical training at Marquette, interned at Milwaukee County Hospital and completed residency at Milwaukee Children's Hospital.

Dr. Russell Named Whitewater College Physician

Dr. James Russell, Fort Atkinson, has been appointed college physician and professor of biology at Whitewater State College effective Sept. 1. He will succeed *Dr. Stephen H. Ambrose,* college physician since 1947, who has resigned to devote full time to his private practice. Doctor Russell holds a doctor of philosophy degree in pharmacy and pharmacology and a doctor of medicine degree from the University of Wisconsin. He is a member of the American Academy of General Practice and a Fellow in the American College of Sports Medicine. Doctor Russell opened his office in Fort Atkinson in 1947 and was joined in 1958 by *Dr. Henry W. Aufderhaar.* Doctor Aufderhaar and Dr. Frank Beran, who is completing a residency in surgery at Madison General Hospital, will share the duties at the college health center with Doctor Russell, making more extensive service possible.

Green Bay Has Disaster Training Drill

Two Green Bay physicians, *Drs. Thomas J. Beno* and *John L. Ford,* directed the mock disaster training drill staged in May at the Veterans Memorial Arena in Green Bay. Members of the Brown County Medical Society, St. Vincent Hospital personnel, Civil Defense, the Green Bay Fire Department and 100 Boy Scouts took part in the disaster plan rehearsal. Ambulances, station wagons, fire trucks, and school buses carried the "injured" to St. Vincent Hospital where more than 30 Green Bay doctors and hospital personnel "treated" the casualties. At noon, a hospital spokesman said disaster "casualties" had been cared for and operations were termed successful.

Brown County Hospital Care Program Lauded

Brown County Hospital was the first county hospital to have a psychiatrist on the staff, and since the active treatment program has been stepped up, results have been encouraging. This was learned by the State Comprehensive Mental Health Planning Committee when it met in May at the hospital with Supt. Lynn Lucia and Green Bay psychiatrist, *Dr. Charles Wunsch.* Lucia paid tribute to the Brown County Medical Society, and stated that there has been a great increase of voluntary admissions from general practitioners. Doctor Wunsch said, "One of our aims has been to get patients to come in on a voluntary basis, and I think we have reached this."

Dr. Mirhoseini Named to American Board of Surgery

Dr. Mahmood Mirhoseini, a member of the Medford Clinic staff since June of 1963, has been informed that he has been certified as a member of the American Board of Surgery.

Sheboygan Hospital Auxiliary Hears Dr. Houfek

"Health Care for the Aged—Operation Home Town" was the topic of *Dr. Edward E. Houfek* when he addressed St. Nicholas Hospital Auxiliary in Sheboygan on current legislation in Congress. The Sheboygan psychiatrist, physician and director of Sheboygan Guidance Center is a member of Medical Speakers Bureau of Sheboygan.

Dr. Samp Addresses C of C Secretaries

Dr. Robert J. Samp of Madison was the featured speaker at the opening session of the second annual Wisconsin Chamber of Commerce office secretaries conference at the Park Motor Inn at Madison.

Dr. Weston to Head Wisconsin Medical Alumni

Dr. Frank L. Weston, clinical professor of medicine at the University of Wisconsin Medical School, was elected president of the Wisconsin Medical Alumni Association Friday succeeding *Dr. Phillips T. Bland,* Westby.

Others elected: *Dr. Herbert Pohle,* Milwaukee, a specialist in internal medicine, president-elect; *Dr. Richard Wasserburger,* Madison, secretary-treasurer; and *Dr. D. J. Freeman,* Wausau, board of directors. Three other directors were reelected: *Dr. Robert F. Schilling,* Madison, and *Drs. Herbert Giller* and *Silas Evans,* Milwaukee.

Doctors Wasserburger and Schilling are UW Medical School faculty members, and Doctors Giller and Evans are on the Marquette Medical School faculty.

Dr. Bruhn Elected President of Hospital Staff

Dr. Irwin Bruhn, Walworth–Fontana physician, has been elected president of the medical staff of the Harvard Memorial Hospital, Walworth.

Dr. Goetsch Seeks Reelection

Dr. O. F. Goetsch of Hustisford is seeking reelection as Dodge County coroner. Doctor Goetsch first served as county coroner by appointment of Gov. Walter Kohler and following that, was elected for two terms.

Dr. Gundersen Speaks at Fete

Dr. Gunnar Gundersen, prominent La Crosse physician and graduate and former regent of the University of Wisconsin, discussed aspects of Norwegian-American physicians and their contributions to medicine June 13 at the dinner of the Norwegian-American Historical Association in Chicago. Doctor Gundersen has practiced medicine since 1920 in his native city of La Crosse, where in 1927 he was co-founder of the Gundersen Clinic. He has been president of the American Medical Association and the State Board of Health, a member of the International College of Surgeons and of Det Norske Medicinske Selskap, and a director of the La Crosse Community Chest.

Milwaukee Doctors on TV Series on Babies

"What's Best for Baby?". Ten Milwaukee physicians answered that question in a series of 11 television programs which ended June 11 on WTMJ-TV's "Today for Women" show. Participating physicians were *Drs. John R. Flanary, John J. Czajka, Richard A. Berk, Donald J. Cohen, Lillian M. Thomas, Leroy Mitcham, Thomas A. Prier, Rex Ruppa, Kenneth J. Winters* and *J. C. Peterson.*

Three Milwaukee Hospitals Elect Officers

The medical staffs of Milwaukee, St. Michael and West Allis Memorial Hospitals have recently elected officers for 1964. At Milwaukee Hospital, the staff has elected *Dr. Einar R. Daniels*, chief and *Dr. Donald S. Thatcher*, vice chief of staff. *Dr. Charles L. Junkerman* was reelected secretary. *Dr. John R. Evrard* has been selected as chief by the staff of St. Michael Hospital, with *Dr. C. Hugh Hickey* elected as secretary-treasurer. Reelected to office at West Allis Memorial Hospital are *Drs. William G. Longe*, chief of staff; *William W. Baird*, vice chief of staff; and *Carl Zenz*, secretary-treasurer.

Dr. McLane Supervises Resuscitation Course

Dr. Hugh McLane, chairman of the Fond du Lac county division of the Wisconsin Heart Association's program committee, supervised a course in external massage and mouth-to-mouth resuscitation in May before nurses and physicians of St. Agnes Hospital, Fond du Lac. *Dr. Jane Koll*, division chairman, presided at the meeting.

Resusci-Anne Demonstrated for Hospital Auxiliary

"Resusci-Anne" is the name of the machine *Dr. Robert E. Currie* of Kenosha used to demonstrate mouth-to-mouth resuscitation at the meeting of St. Catherine's Hospital Auxiliary in Kenosha. The unit was purchased by the auxiliary as a gift for the hospital.

Dr. Franke Addresses Student Nurses of State

Keynote speaker at the recent annual meeting of the Wisconsin Student Nurses Association was *Dr. Glenn H. Franke* of Milwaukee.

Dr. Collentine Speaker for Tri-State Hospital Assembly

Dr. George E. Collentine, Jr., Milwaukee, spoke on the "Strategy of Therapy for Burn Patients" at the Annual Tri-State Hospital Assembly at Chicago.

Dr. Haukohl on TV Panel

Dr. Robert S. Haukohl, president of The Medical Society of Milwaukee County, participated in a panel entitled "Hospital Report," broadcast over WTMJ-TV in May as a feature of the Milwaukee observation of National Hospital Week. The program was presented on "The Open Question" show.

Kiwanians Hear Dr. Houghton

"The Kerr-Mills Bill" was *Dr. John H. Houghton's* subject when he addressed a meeting of the Wisconsin Dells Kiwanis Club in June.

Milwaukee Rotary Honors Dr. Blount

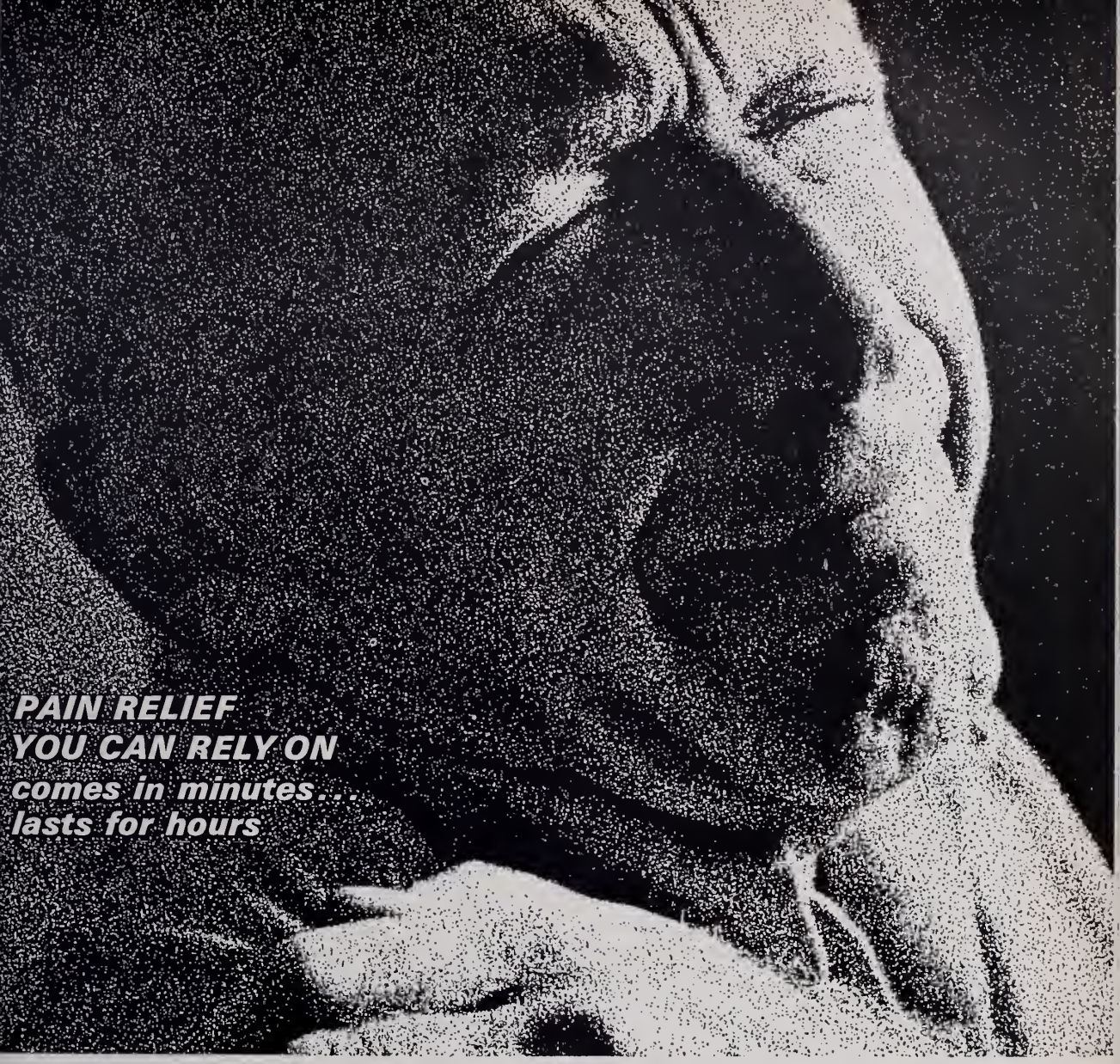
Dr. Walter P. Blount, Milwaukee, nationally known orthopedic surgeon, was one of three men honored by the Rotary Club of Milwaukee for outstanding work in their professions. Irwin Maier, publisher of THE MILWAUKEE JOURNAL and THE MILWAUKEE SENTINEL, was also honored. Mrs. Larry H. Smith accepted an award for her late husband, a Milwaukee hotel operator who was active in many civic groups. Doctor Blount is head of the orthopedic surgery department in Marquette University School of Medicine and formerly was chief of orthopedics at Milwaukee Children's Hospital. He was cited for developing orthopedic devices such as stainless steel staples to control bone growth in children. J. Martin Klotsche, University of Wisconsin–Milwaukee, called Doctor Blount "a perfectionist" who also had the ability to establish a human relationship with his patients.

Dr. Straughn Kiwanis Speaker

Dr. Robert Straughn spoke at the June 1 meeting of the Madison Kiwanis Club at the Loraine Hotel. The Madison physician showed a film, "Gift of Health," prepared by the American Medical Association.

Dr. Hartzell Gets Bachelor's Degree

Dr. Richard Hartzell of Grantsburg, who never received a bachelor's degree, finally received his sheepskin 20 years later on May 31 from Otterbein College in Ohio. He was enrolled in Otterbein during World War II, fulfilled the requirements for medical school but did not have enough credits to receive his B.S. degree.



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Dr. Emanuel Addresses Thoracic Society

Dr. Dean A. Emanuel of the Marshfield Clinic and Frederick J. Wenzel, director of laboratories at the clinic, presented a paper on "Histopathology and Immunology of Farmer's Lung" at the annual meeting of the American Thoracic Society late in May at New York City. The meeting was held in conjunction with a session of the National Tuberculosis Association. The paper presented by Doctor Emanuel dealt with a study undertaken with *Dr. Ben R. Lawton*, also of the Marshfield Clinic, over the past three years which has resulted in new findings about the causative agent of this serious disease.

Dr. Phillips Opens Practice in Owen

Since July 1, Owen once again has a resident physician. He is Dr. Thomas A. Phillips, formerly of the staff of the Veterans Administration Hospital in Tomah, and prior to his association there, staff physician in hospitals in Texas and Virginia. When he opened his practice in Owen, Doctor Phillips ended a void in medical services that had existed since Dr. John Peden discontinued his practice there in June of last year.

A native of Wales, Doctor Phillips received his degrees of Bachelor of Medicine and Bachelor of Surgery in 1942 at the University of Birmingham, England. He also attended Victoria University of Manchester, England, and obtained a diploma in Public Health in 1954. The following year his thesis on "Social Causes of Infant Mortality" won him a Doctorate in Medicine.

After joining the regular Army Corps in 1943, Doctor Phillips served as a medical officer in Britain and Kenya, East Africa, until 1946. His medical experience in the British Isles included hospital posts in North Wales, general practice in South Wales, and posts as public health physician in Lancashire and Medical Officer of Health in an area best known for its 12th century castle in which heirs to the British throne are invested as "Prince of Wales."

New Medical Center for Port Washington

Construction is progressing steadily on the new medical center on the north side of Port Washington. *Drs. John F. Walsh, Robert F. Henkle* and *William A. Corcoran, Jr.*, are presently associated as Walsh and Henkle Medical Group, but a fourth doctor is expected to join the staff when the new center is completed.

Dr. Polacek Certified by ABS

Dr. Michael A. Polacek of Milwaukee has recently received his certification from the American Board of Surgery.

Drs. Brew, Demergian, Hurst Certified

Three members of the staff at the Jackson Clinic in Madison recently were successful in passing their board examinations and have been certified in their specialties. They are: *Dr. Barbara A. Brew*, obstetrics and gynecology; *Dr. Vaughn E. Demergian*, plastic surgery; and *Dr. D. William Hurst*, internal medicine.

Dr. McAleavy ABA Diplomate

Dr. John C. McAleavy of Madison is one of the group of physicians certified as diplomates of the American Board of Anesthesiology as of Dec. 8, 1963.

Dr. Nemeth Moves Office to Milwaukee

Dr. Charles Nemeth has announced the removal of his home and office from Fond du Lac to Milwaukee.

State University to Share in Grants

The University of Wisconsin is one of a number of institutions which will receive grants for basic medical research and for training of medical scientists from the Life Insurance Medical Research Fund during the coming year. The university is receiving a grant of $22,000 for research by Dr. John W. Porter, Ph. D., clinical professor of physiological chemistry, on the role of malonyl CoA in the biosynthesis of lipids.

Dennis G. Maki of Edgar is one of 19 exceptionally promising medical students who are being awarded Medical Scientist Fellowships from the Life Insurance Medical Research Fund. The research grants are in fields that can throw light on basic disease mechanisms. The Fund gives broad aid to research into the nation's leading cause of death, diseases of the heart and circulatory system.

Dr. Gungor Joins Neillsville Clinic Staff

Since July 1, *Dr. Bahri Gungor* has been associated with *Dr. M. V. Overman* and *Dr. K. F. Manz* at the Neillsville Clinic. In making his announcement, Doctor Gungor stated that he was making tentative plans to continue providing medical service to Loyal, spending probably three half days there each week.

Dr. Slocumb Settles at Twin Lakes

Dr. C. O. Slocumb has signed a 10-year lease which will make the long-planned medical center at Twin Lakes a reality. By July 1, Doctor Slocumb expected to be located in a part of the former Cottage School building, where remodeling of two rooms got under way in June. A graduate of the University of Wisconsin Medical School, Doctor Slocumb has been interning at Illinois Masonic Hospital, Chicago. He hopes to have another physician with him a year from now.

Colleagues Honor Dr. Cooksey

A testimonial dinner for *Dr. Rogers T. Cooksey*, at which tribute was paid to his years of devoted service to Madison General Hospital, the community and the medical profession, was sponsored by his surgical colleagues on the hospital staff June 2 at the State Medical Society building in Madison.

Doctor Cooksey has been chief of surgery at Madison General Hospital, where he interned from 1915 to 1916. In World War I, he was battalion surgeon with the 127th Infantry of the 32nd Division and served overseas two years. He was awarded the French Croix de Guerre. For some nine years, Doctor Cooksey was an assistant to the late Dr. Reginald Jackson. He entered private practice in 1923.

During his tenure at Madison General Hospital surgical department, he developed the residency and graduate training programs. He was a pioneer in developing surgical procedures and techniques at the hospital.

Doctor Cooksey is a native of Bowling Green, Ky., and received his bachelor's degree at Ogden College in Bowling Green, and his medical degree at Vanderbilt University. He is a Kentucky Colonel.

Dr. Walker Addresses Milwaukee Turners

"Heart Disease in Relation to Prolonged Physical Exercise" was the topic of *Dr. John A. Walker*, Milwaukee internist, when he addressed a meeting of the Milwaukee Turners Club on June 19 in Milwaukee. Doctor Walker appeared through Wisconsin Heart Association sponsorship. He is a member of its State Physician Speaker's committee.

Dr. Reichardt Heads Stevens Point "Disaster Day"

Under the leadership of *Dr. F. W. Reichardt*, a Portage County emergency medical services disaster day exercise was staged May 23 to provide training in, and testing of, plans for effective disaster operation of St. Michael's Hospital in Stevens Point, River Pines Sanatorium in Whiting, an emergency hospital set up at River Pines, and the emergency blood procurement center.

A make-believe tornado was the "disaster" which hit P. J. Jacobs and Pacelli High Schools that day to send student volunteer "victims" to St. Michael's Hospital, with the overflow going to River Pines.

Serving with Doctor Reichardt at the disaster area was *Dr. S. R. Miller*, also of Stevens Point. Comprising the mobile hospital unit were *Drs. John F. Riordan, Robert H. Slater* and *James R. Sevenich*, Stevens Point; *V. A. Benn*, Rosholt; and *Henry A. Anderson*, River Pines Sanatorium. Two Stevens Point physicians, *Drs. Francesco Sciarrone* and *Angelo Milano*, served in the blood procurement unit.

In the St. Michael's Hospital emergency unit were *Dr. Robert H. Rifleman*, Stevens Point, who provided psychiatric care; *Drs. Albin J. Sowka*, chief, *Frank C. Iber, George H. Anderson* and *William C. Sheehan*, all of Stevens Point, burn centers; *Drs. Maurice G. Rice, Richard A. Eckberg, John R. Erickson, A. G. Dunn* and *Anne G. Schierl* (anesthesia), also of Stevens Point, general surgery; *Dr. Francis E. Gehin* and *Dr. R. H. Sanders* or *Dr. Albert M. Kohn*, Stevens Point, radiation sickness; and *Drs. Robert H. Bickford, Paul N. Sowka, J. A. Litzow* and *Herbert P. Benn*, Stevens Point, admitting and disposition.

Participating with members of the Portage County Medical Society in the disaster test were nurses, other medical personnel, city and county law enforcement officials, civil defense auxiliary police, and CD communications and transportation people.

Doctor Reichardt and Frank Guth, Portage County civil defense director, were both satisfied with the exercise, which demonstrated strong points and also uncovered weaknesses, and in general provided information which would be of value in the event of some unforeseen disaster.

Drs. McKenna, Fox Open Clinic

Dr. John E. McKenna and *Dr. Theodore C. Fox* have moved to their new General Clinic at Antigo. One of the most modern medical buildings in that section of the state, the clinic has more than 20 rooms and is equipped with facilities for four physicians. *Dr. E. A. McKenna* has also moved into the clinic. *Dr. Donald V. Blink* of Wisconsin Rapids joined the group in August. He is a native of Oshkosh and will be engaged in general practice.

Civic Clubs Hear Dr. Cupery

Dr. Dowe Cupery, Markesan, who served in Ethiopia as a short-term medical missionary, gave a talk illustrated with colored slides late in May at the 25th anniversary observance of the Princeton Rotary Club and their Rotary Anns. The week following, Doctor Cupery addressed Ripon Kiwanians at a meeting at the Republican House.

While in Ethiopia, the doctor worked in a mission hospital, where facilities were good, but there was a shortage of physicians. He and his wife, a registered nurse, also visited Cairo and spent considerable time in Kuwait where a friend of theirs resided.

Dr. McDonald Opens Office in Tucson

Dr. Robert E. McDonald, a diplomate of the American Board of Obstetrics and Gynecology, has announced the opening of an office at Tucson, Ariz. Doctor McDonald formerly practiced medicine in Milwaukee.

State Pathologists Certified As Diplomates

Six Wisconsin physicians are among the 310 pathologists certified this spring as diplomates in pathology. They are: *Drs. E. B. Wohlwend*, Beaver Dam; Daniel P. Collins, Hales Corners; *Harold Wagner*, Kenosha, (forensic pathology), *Dale E. Van Wormer*, Madison; *George C. Bares*, Wauwatosa; *Robert L. Kascht*, Waukesha.

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PHYSICIANS NEWS *continued*

Commission Grants Dr. Pierce's Request

Dr. Dennis F. Pierce has been granted permission by Franklin's plan commission to establish a medical library and retiring medical practice in his home. Doctor Pierce, who presently has his offices in Hales Corners, hopes to retire gradually, and the moving of his office to a building on his estate in Franklin is a gradual move in that direction, he told the commission.

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NEW FIFTY YEAR CLUB MEMBERS of the State Medical Society are pictured at the society's annual dinner in Milwaukee in May. From left to right, seated, are: Doctors Buckner, Kerscher, Docter, and Busse. Standing are Doctors Allen, Tucker, Simons, and Nadeau. A total of 12 physicians were honored.

State Medical Society Honors Twelve Doctors for Fifty Years Service

Twelve Wisconsin physicians were honored by the State Medical Society Tuesday, May 12, when they were awarded memberships in the Society's "Fifty Year Club."

Completing 50 years of service in the medical profession this year are: *Drs. Judson S. Allen*, Norwalk; *N. Philip Anderson*, La Crosse; *Alfred A. Busse*, Jefferson; *Homer M. Buckner*, Dodgeville; *John C. Docter*, Racine; *H. R. Foerster*, Milwaukee; *Raymond J. Groves*, Lodi; *Richard H. Juers*, Wausau; *Edward J. Kerscher*, Casco; *Emile G. Nadeau*, Green Bay; *Neal S. Simons*, Whitehall; and *William J. Tucker*, Ashland.

They received their awards at the State Medical Society's annual dinner, held at the Hotel Schroeder, Milwaukee, in conjunction with the 123rd Annual meeting program.

The doctors, all medical school graduates in 1914, represent a total of 600 years of experience in the medical profession. Seven are general practitioners. The others are specialists in eye, ear, nose and throat, dermatology, pediatrics and surgery.

Seven were born in Wisconsin, five in other states —Vermont, Minnesota, Missouri, New York and Illinois.

They practice in communities ranging in size from Milwaukee to a small town of under 500 residents.

Four of the twelve have served as presidents of their county medical societies.

Dr. Judson S. Allen has practiced general medicine in the town of Norwalk, in Monroe County. Active in community affairs, Doctor Allen has served Norwalk's municipal government for over 25 years.

Now retired is Dr. N. Philip Anderson of La Crosse. A general practitioner, Doctor Anderson served in the medical corps during the World War I and has served both as president and secretary of the La Crosse County Medical Society.

Dr. Alfred A. Busse was born in Milwaukee and received his medical training at Marquette University. During his general practice in Jefferson, he distinguished himself, not only by serving as a president of the Jefferson County Medical Society, but as president and then governor for the Wisconsin officers of the College of Chest Physicians.

Practicing in Prairie du Sac, Mount Horeb and Dodgeville, Dr. Homer M. Buckner developed a special interest in obstetrics and pediatrics. His medical training was taken at Loyola University, Chicago, Ill., his residency at Madison General Hospital.

Although born, raised and medically educated in Illinois, Dr. Raymond J. Groves came to Madison for his internship upon completion of his medical education at Loyola University. He settled in Lodi and has carried on an active, individual general practice since completion of his internship.

A Green Bay eye, ear, nose and throat specialist, Dr. Emile G. Nadeau, has served as president of the former Brown–Kewaunee–Door County Medical Society and on two committees for the State Medical Society. His son, following in his footsteps, joined him in practice in 1948.

Past president of the Racine County Medical Society is Dr. John C. Docter, who was born in Mayville, Wis., and attended Marquette University. Tak-

ing his postgraduate work at Harvard, Doctor Docter practiced medicine in Montana before settling in Racine and devoting his practice to his specialty, pediatrics.

Although he formally retired and closed his doors in 1956, Dr. Neal S. Simons returned to the practice of medicine on a part-time basis in 1960. Doctor Simons, also an eye, ear, nose and throat specialist, practires in Whitehall and has served as president of the Trempealeau–Jackson–Buffalo County Medical Society.

Another specialist is being honored. Dermatologist, Dr. H. R. Foerster, Milwaukee, has been engaged in practice since completing his residency at Vanderbilt Clinic of Columbia University.

Formerly a member of the Marshfield Clinic and now located in Wausau is Dr. Richard H. Juers. Doctor Juers moved to Wausau in 1933 where he has been able to devote much attention to his special interest, obstetrics.

In addition to serving the community of Ashland, Dr. William J. Tucker, a surgeon, was last year given the "Outstanding Citizen of the Year" award by the county Veterans of Foreign Wars organization. Doctor Tucker was born in St. Louis, Mo., where he received his medical education. His residency years were spent at the Mayo Clinic, Rochester, Minn.

Dr. Edward J. Kerscher was not only born in the Casco area, but he returned there after graduating from Marquette University School of Medicine, Milwaukee, practicing general medicine. In 1950 the community and surrounding area honored him for his interest and service to them, pointing out that he had delivered some 4,322 babies during his 36 years of practice.

In presenting the Fifty Year Club awards, the Society president, *Dr. W. J. Egan*, commented, "Since these men graduated from medicine, the life span of human beings has increased some 19 years. Two world wars have served as the impetus for research discoveries that have revolutionized medicine. But nothing can replace the courage these men have shown or the personal service they have given."

Dr. Holmes Now in Wausau

Dr. Guy W. Holmes, former Marinette pathologist, has accepted a new position in Wausau and moved there July 1 with his wife and three children.

Sheboygan Club Honors Dr. Nause

Dr. F. A. Nause was presented a plaque in appreciation of his 40 years of service to the Sheboygan Optimist Club in June. The Sheboygan physician is a charter member and past president of the club. He served as the first president of the Board of Health for the city of Sheboygan from 1929 to 1938 and from 1930 to 1938 as the appointed city physician. He was also a part-time health officer for the city from 1957 to 1962.

Dr. McMahon Gives $203,205 to MU

A Milwaukee physician, who was Marquette University's first professor of obstetrics in 1913, has assigned his estate, valued at $203,205, to Marquette to create a chair in obstetrics and gynecology. He is *Dr. Joseph P. McMahon*, 84, whose interest in medicine was spurred by the fact that his mother died of puerperal infection. His leadership resulted in passage of a 1909 state law governing midwife practice.

The chair will honor Doctor McMahon's parents, Patrick J. and Margaret G. McMahon. In return, Doctor McMahon will receive a lifetime annuity from the university.

A Marquette graduate, Doctor McMahon received his M.D. degree from the old Wisconsin College of Physicians and Surgeons in 1903. He interned at the old St. Joseph's Hospital, now the National Convalescent Home, practiced briefly at Union Grove, took graduate courses in Vienna and New York City, then returned to Milwaukee.

He was medical editor of the WISCONSIN MEDICAL JOURNAL from 1910 to 1923, treasurer of the Milwaukee Academy of Medicine from 1914 to 1926 and president of the academy in 1928. He is a past president of the Marquette University Medical Alumni Association.

Marquette's chancellor, Father Edward J. O'Donnell, S.J., said that MU plans to raise an additional $300,000 to provide about a half-million endowment for the new chair, which will be filled by the chairman of Marquette's obstetrics and gynecology department.

New UW Appointments

Dr. Robert F. Schilling is the new chairman of the Department of Medicine in the University of Wisconsin Medical School succeeding *Dr. Ovid O. Meyer*, who retired June 30 after 20 years in the post. On the day of his retirement, Doctor Meyer was honored by the department at a banquet at the Madison Club.

Doctor Schilling, the developer of the world-famous "Schilling Test" for the diagnosis of pernicious anemia, was appointed to his new post by James F. Crow, Ph.D., acting dean of the medical school, who also named *Dr. John H. Juhl* as new chairman of the Department of Radiology. Both appointments were effective July 1.

Dr. Otto A. Mortensen, associate dean of the medical school, has temporarily assumed the duties of Doctor Crow, while the latter studies at Stanford University this summer. Before his departure for California, Doctor Crow also reported that he would continue to serve as acting dean of the medical school after his return if a permanent dean has not yet been selected.

Doctor Juhl replaced *Dr. Lester W. Paul*, who retired from the chairmanship of radiology. All other medical school department chairmen were reappointed.

Dr. Sievert at Madison General Hospital

Dr. Robert A. Sievert became the director of the Physical Medicine-Rehabilitation Department at Madison General Hospital on July 1. Born in Milwaukee, Doctor Sievert attended the University of Rochester (N.Y.) from 1947 to 1949, then transferred to the University of Wisconsin in Madison where he received a B.S. in metallurgical engineering in 1953 and an M.S. in the same field in 1954. He served as a first lieutenant with the United States Air Force.

R. A. Sievert, M.D.

Doctor Sievert graduated from the University of Wisconsin Medical School in 1960, and after serving his internship at Madison General, spent a year as a resident physician in internal medicine at La Crosse Lutheran Hospital.

Doctor Sievert completed a residency training program at the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center. He has completed the written examination portion of requirements for certification by the American Board of Physical Medicine and Rehabilitation.

UW Clinical Faculty Appointments

Appointment and reappointment of 86 members of the University of Wisconsin Medical School "clinical" faculty, who serve without salary, were made by UW regents in June as a part of their 1964–1965 budget action. Most of the appointees are Madison area physicians and surgeons who aid the medical school in instruction, research, and service functions.

Clinical professor appointments included: Gynecology and Obstetrics, *Edwin F. Schneiders;* Medicine, *Abraham M. Gottlieb.*

Clinical associate professors: Medicine, *Robin N. Allin, Hubert C. Ashman, Donald G. Dieter, Robert Farrell, Francis L. Hummer, J. Richard Johnson, Lawrence Prouty, Anthony J. Richtsmeier, Royal Rotter, John R. Talbot,* Benton C. Taylor; Pathology, *Philip G. Piper;* Psychiatry, *Leonard J. Ganser, Gilbert B. Tybring;* Surgery, *Palmer I. Kundert, Rollo D. Lange, John P. Malec, Maurice G. Rice, Sion C. Rogers, Charles B. Taborsky.*

Clinical assistant professors: Anesthesiology, *Diane C. Bohlman, Gordon M. Garnett, Carl W. Schmidt;* Gynecology and Obstetrics, *George C. Hank, William V. Luetke, William C. Mussey, Donald O. Price;* Medicine, *Robert L. Beilman, Elston L. Belknap, William P. Crowley, Charles A. Doehlert Jr.,* William N. Donovan, *Lawrence T. Giles, John M. Irvin, Thomas S. Kemp, William Rock, Edward K. Ryder, A. Paul Vastola Jr.;* Pathology, *Dean M. Connors, Etheldred L. Schafer, Donald J. Stevenson;* Pediatrics, *Thomas V. Geppert, William A. Tanner;* Preventive Medicine, William I. Lea, *Josef Preizler;*

Psychiatry, *Mary Berg, Edward M. Burns, Henry C. Everett, Martin Fliegel, Konstantin Georcaris, Harold N. Lubing, William H. Lyons,* Rudolph E. S. Mathias, *Robert E. O'Connor,* Asher Pacht, Nolan E. Penn, *Bryant Roisum,* Frank Rundle, *Kenneth H. Rusch, Max M. Smith, Ervin T. Teplin, Judith Walton, Walter J. Urben;*

Radiology, *Margaret Winston;* Surgery, *Carl W. Aageson, Norman O. Becker, Fred Blum Jr., Edward I. Bolden,* Guillermo deVenecia, *Theodore L. Hartridge, William B. Hobbins, Fred W. Kundert, James F. Land, W. B. Larkin, James McIntosh, James Miller, Dwain E. Mings, Eugene J. Nordby, Donald Peterson, Ray H. Quade, Anton Schoenenberger, John K. Scott, P. Richard Sholl, Henry M. Suckle.*

Madison "Y" Hears Local Physicians

Four Madison physicians participated in the second series of premarital counseling sessions under professional leadership in July at the YWCA in Madison. *Dr. C. R. Jackson* and *Dr. Walter L. Washburn* discussed the medical-physical aspects of marriage July 10, and on July 24, *Drs. Leigh M. Roberts* and *Bryant H. Roisum* explained the psychology of marriage relationships.

Dr. Shampo Joins Richland Clinic

Dr. Dale R. Shampo has joined the staff of the Richland Medical Clinic in Richland Center. A 1960 graduate of the University of Wisconsin School of Medicine, Doctor Shampo interned at Erlanger Hospital in Chattanooga, Tenn., and had two years of residency in a Galveston, Tex., hospital and one in a Chicago hospital. He has specialized in internal medicine and orthopedics.

State Physicians Elected ACOG Fellows

Dr. Luis B. Curet of the University of Wisconsin Hospital Gynecology Department, and Dr. Richard R. Thornton of Milwaukee have been elected junior fellows in the American College of Obstetricians and Gynecologists. *Drs. Walter R. Schwartz* and *Chase Whitley Wolfe,* Milwaukee; *Paul E. Carroll,* Waukesha; *John L. Claude,* Oconomowoc; *John C. Ellis, Jr.,* Madison; and *Hugh P. Rafferty,* Kenosha, have been elected fellows-elect in the ACOG.

Dr. James Leaves Valders for Milwaukee

Dr. Richard L. James, who joined *Dr. W. E. Acheson* in general practice in 1959 at Valders, has moved from that community to Milwaukee, where he started a residency in obstetrics and gynecology at Milwaukee Hospital in July.

Before moving to Valders with his family, Doctor James spent two years in Germany with the U.S. Army, as an army doctor with a small unit stationed near the Czechoslovakian border.

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THANKS

TODAY'S HEALTH magazine, published by the American Medical Association, for the continuing collection of original artwork used on its covers.

The collection began in 1962 and thus far eight paintings have been received. They have been titled: Spanish Doctors in the Old Southwest, William Beaumont Frontier Army Surgeon, Doctors of the Air Waves, Beaumont Aiding Alexis St. Martin, Doctors of the Revolutionary War, Commemorating James Craik, M.D., the First "White House" Physician, Frontier Doctors Helped Win the West, and Doctors of the Gold Rush Days. These paintings, done in beautiful watercolor technique, are on display in the State Medical Society building. In making this collection available Mr. Kenneth N. Anderson, editor of TODAY'S HEALTH, stated: The story of medicine has always captured the imagination of the artists of the world. And the illustrator frequently has communicated through the eye of the viewer a message more vivid than is possible with the spoken or written word. Because of the impact of such imagery, TODAY'S HEALTH magazine has commissioned several artists to portray for its readers the history of medicine in America, from the Colonial period to our own era of "TV Doctors."

Commemorating James Craik, M.D., the First "White House" Physician

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HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS

MEDICAL MUSEUM

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JULY 15, 1964

NEW MEMBERS

John F. Alstadt, 806 Medical Group USAF, Sawyer AFB, Michigan.
Tamnit Ansusinha, St. Mary's Hospital, Madison.
William A. Cook, 324 West Main Street, Waukesha.
Phillip A. Dibble, 1313 Fish Hatchery Road, Madison 15.
Gordon L. Eckert, 5746 Forsythia Place, Madison.
Worthy David Gemmill, 59 Racine Street, Menasha.
Herman P. Gladstone, 1300 University Avenue, Madison.
Vincent L. Gott, University of Wisconsin Department of Surgery, Madison 6.
Ronald E. Grossman, 7325 Crossway Road, Milwaukee.
Seymour L. Halleck, 1300 University Avenue, Madison.
Jack D. Heiden, 1300 University Avenue, Madison.
Edmund B. Jacobs, 1300 University Avenue, Madison.
Theodore L. Johnson, 8111 Currie Avenue, Milwaukee.
Anthony Jurisic, Spring Valley.
Egbert Kamstra, 2308 20th Avenue, Monroe.
Donald Knepel, 1344 Creston Park Drive, Janesville.
Ronald R. Kyllonen, 1404 University Avenue, Madison.
Jacob Lemann, Jr., 8700 West Wisconsin Avenue, Milwaukee.
John R. Litzow, 6745 West Wells, Milwaukee.
Charles Marks, 8700 West Wisconsin Avenue, Milwaukee.
Jerome A. Megna, 1845 North Farwell, Milwaukee.
Edwin G. Montgomery, Jr., 229 South Main Street, Thiensville.
John P. Mullooly, 124 South 76th Street, Milwaukee.
Albert A. Nemcek, 8700 West Wisconsin Avenue, Milwaukee.
Herman D. Nienhuis, 1344 Creston Park Drive, Janesville.
Nilandino A. Oddis, 5854 South Packard Avenue, Cudahy.
Kenneth K. Pavlik, 5 West Rollin Street, Edgerton.
Eugene R. Rightmyer, 2266 North Prospect Avenue, Milwaukee.
Charles A. Skemp, 312 State Street, La Crosse.
Mark Evan Speckhard, 135 South Sixth Avenue, West Bend.
Rodney J. Sturm, 224 West Washington Avenue, Madison.
Margery J. Swint, 2718 East Kenwood Boulevard, Milwaukee.
George F. Unger, 161 West Wisconsin Avenue, Milwaukee.
Dale E. Van Wormer, 1300 University Avenue, Madison.
Arthur R. Zintek, R.R. No. 1, Box 315, Richfield.

REINSTATED

James J. McDuffie, 2661 North Teutonia Avenue, Milwaukee.
Katherine E. Stewart, 213 Garfield Avenue, Eau Claire.

CHANGES OF ADDRESS WITHIN CITY

John G. Beck, 1715 Rhode Island Street, Sturgeon Bay.
Carl E. Bellehumeur, 8200 North Teutonia Avenue, Milwaukee.
John P. Canavan, 111 East Wisconsin Avenue, Neenah.
Paul E. Carroll, 1111 Delafield Street, Waukesha.
Owen L. Felton, 2653 Stevens Street, Madison.
O. H. Foerster, 3333 North Shepard Avenue, Milwaukee.
R. G. Frantz, 1111 Delafield Street, Waukesha.
Martin Z. Fruchtman, 901 East Roberta Avenue, Waukesha.
Bruce E. Greenfield, 403 Wisconsin Avenue, Beloit.
Conrad Heinzelmann, 425 East Wisconsin Avenue, Milwaukee.
Elmer E. Johnson, 4513 Vernon Boulevard, Madison.
Alex M. Kane, 4273 West Highland Avenue, Milwaukee.
Joseph M. King, 1825 North 74th Street, Milwaukee.
Ivan Knezevic, 3353 South Wallmer Road, Milwaukee 19.
Curtis C. Knight, 765 West Washington Avenue, Madison.
V. W. Koch, 1009 Oakland Avenue, Janesville.
Richard J. Krill, 8200 North Teutonia Avenue, Milwaukee.
James M. Lee, 5822 Lomond Street, San Diego, Calif.
Thomas E. Lynn, 3430 Langlade Road, Green Bay.
Austin J. McSweeny, 306 West Milwaukee Street, Janesville.
Albert J. Motzel, Jr., 1111 Delafield Street, Waukesha.
James E. Ney, 621 Bel Air Circle, Milwaukee 13.
Richard J. O'Malley, 8200 North Teutonia Avenue, Milwaukee.
Jack A. Peterson, 1111 Delafield Street, Waukesha.
Michael A. Polacek, 5810 West Oklahoma Avenue, Milwaukee.
Jesus T. Querol, 436 East Longview Avenue, Appleton.
David M. Regan, 100 West Wisconsin Avenue, Neenah.
Frank E. Rettig, 330 West Lisbon, Milwaukee.
John R. Schroder, 1344 Creston Park Drive, Janesville.
Charles M. Schroeder, 8700 West Wisconsin Avenue, Milwaukee.
Earl G. Schulz, 1111 Delafield Street, Waukesha.
Donald J. Taylor, 222 North Midvale Boulevard, Madison.
James Tibbitts, 710–12 North Webb Avenue, Reedsburg.
Benjamin Wein, 255 North Farwell Avenue, Milwaukee.
Wilson Weisel, 2266 North Prospect Avenue, Milwaukee.
Stephan I. Wojcechowskyj, 2671 South 76th Street, Milwaukee.
LeRoy R. Wolski, 2477 North 52nd Street, Milwaukee.

CHANGES OF ADDRESS FROM CITY TO CITY

Howard Albright, Thiensville, to 2243 North Prospect Avenue, Milwaukee.
R. F. Barta, Milwaukee, to 14600 Crestwood Court, Elm Grove.
Edward J. Beil, Hales Corners, to 7963 Ninth Avenue South, St. Petersburg, Fla.

Edwin L. Bemis, Milwaukee, to 12665 Cardinal Crest Drive, Brookfield.
Robert S. Bujard, Jr., Winnebago, to 301 Troy Drive, Madison.
Ralph A. Clark, Elm Grove, to 3000 South 149th Street, New Berlin.
Albert M. Cohen, Wood, to 6222 West Capitol Drive, Milwaukee.
Donald P. Davis, Shorewood, to 204 Queen Street, Beckley, W. Va.
W. W. Fieber, West Allis, to 8815 Burt Street, Omaha, Neb.
Jordan N. Fink, Evanston, Ill., to 4863 B Carol Street, Skokie, Ill.
Gregory L. Gallo, Madison, to P.O. Box 11, Waukesha.
Joseph J. Grimm, Milwaukee, to Box 144, South Milwaukee.
Richard C. Harris, Madison, to USAF Hospital, Scott AFB, Belleville, Ill.
Paul L. Karrmann, Jr., Milwaukee, to 3324 Waldo Boulevard, Manitowoc.
Robert A. Kebbekus, Wauwatosa, to 324 East Wisconsin Avenue, Milwaukee.
Milton G. Klumb, Fort Lauderdale, Fla., to 3201-B North Buffum Street, Milwaukee.
W. B. Larkin, Marshfield, to 1620 Ohm Avenue, Eau Claire.
Kenneth C. Leenhouts, Menomonee Falls, to Route 2, Box 383A, Waukesha.
Jack R. Lees, Marshfield, to 350 St. Peter and 25th West Fourth, St. Paul, Minn.
Ernest L. MacVicar, Jr., Racine, to 6427 East Hoods Creek Lane, Franksville.
Isadore Mallin, Milwaukee, to 4940 North Kimball Avenue, Chicago, Ill.
Lester O. Mastalir, Burlington, to 6030 West Capitol Drive, Milwaukee.
Stanley Miezio, Madison, to Winnebago State Hospital, Winnebago.
Stuart E. Milson, Wood, to 505 South Military Avenue, Green Bay.
Mahmood Mirhoseini, Athens, to 301 East Conrad Street, Medford.
Charles Nemeth, Fond du Lac, to 1028 East Juneau Avenue, Milwaukee.
Richard S. Ostenso, Marshfield, to 1620 Ohm Avenue, Eau Claire.
Capt. M. A. Rammer, Jr., San Antonio, Tex., to 25 Edwards Street, Ft. Rucker, Ala.
Albert J. Randall, Sarasota, Fla., to 1710 60th Street, Kenosha.
Robert A. Sievert, La Crosse, to 5713 Hempstead Road, Madison.
John O. Simenstad, St. Paul, Minn., to Osceola.
Paul O. Simenstad, Osceola, to 821 Miami Pass, Madison.
W. D. Stovall, Jr., Monticello, to P.O. Box 302, Manteno State Hospital, Manteno, Ill.
G. B. Theil, Fremont, Calif., to State University of Iowa, Iowa City, Iowa.
Thor M. Thorgersen, Wausau, to 715 Tenny Avenue, Waukesha.
Anthony Truszkowski, Milwaukee, to 7873 North Chadwick Road, Glendale.
Frank H. Urban, Milwaukee, to 10425 West North Avenue, Wauwatosa.
George R. Wagner, Milwaukee, to N84 W15787 Menomonee Avenue, Menomonee Falls.
Irving V. Wright, Milwaukee, to 16300 Tomahawk Trail, Brookfield.

NAME CHANGES

Alfredo Cartes, formerly A. Cartes del Rivero.
Ingrid Raits-Jurevics, formerly Ingrid E. Raits.

REMOVED FROM MEMBERSHIP

John E. Bentley, Dane County, at request of County Secretary.
Henry T. Grinvalsky, Portage County, transferred to Washington, D. C.
Joseph R. Kelly, Portage County, at request of County Secretary.
Ernest N. Krueger, Outagamie County, transferred to California.
Robert E. McDonald, Milwaukee County, resigned.
Paul S. Messinger, Milwaukee County, transferred to New York.
Edward P. Onderak, Rock County, transferred to Michigan.
M. S. Saydjari, Barron–Washburn–Sawyer–Burnett County, transferred to Oklahoma.
Lewis F. Scribner, Green County, transferred to New York.
J. D. Weinstein, Milwaukee County, transferred to California.

DEATHS

Evan E. Carl, Milwaukee County, May 29, 1964.
Otto F. Dierker, Jefferson County, April 16, 1964.
Philip J. Eisenberg, Milwaukee County, June 11, 1964.
Alexander F. Harter, Oneida–Vilas County, May 25, 1964.
George T. Hegner, Outagamie County, May 25, 1964.
Leo M. Lifschutz, Racine County, July 4, 1964.
Bruno A. Lungmus, Milwaukee County, May 3, 1964.
William C. Maas, Columbia–Marquette–Adams County, June 5, 1964.
P. E. Oberbreckling, Milwaukee County, April 11, 1964.
Harry H. Schlomovitz, Milwaukee County, June 10, 1964.
Alexander D. Spooner, Milwaukee County, May 7, 1964.
Raymond M. Stark, nonmember, May 25, 1964.
E. A. Strakosch, Winnebago County, June 24, 1964.
Frank W. Van Kirk, Rock County, May 24, 1964.
John B. Wear, Dane County, May 12, 1964.
George B. Wiles, nonmember, April 6, 1964.
Marres H. Wirig, Dane County, June 15, 1964.
J. Howard Young, nonmember, May 27, 1964.

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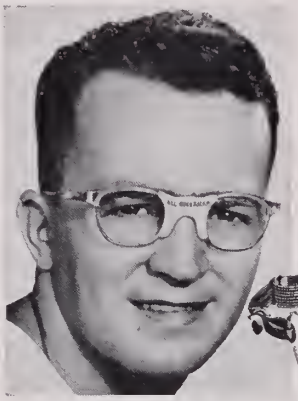

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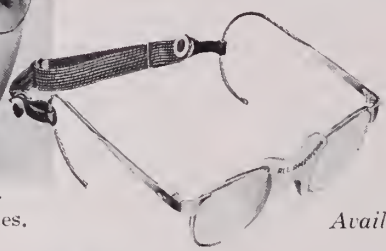

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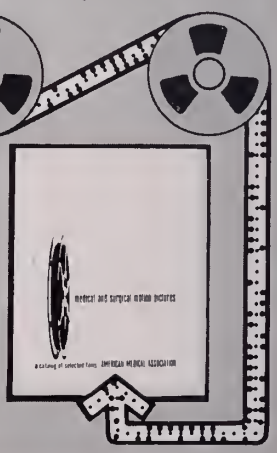

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Wisconsin Licentiates

FOLLOW-UP OF PHYSICIANS PREVIOUSLY NOT LISTED AS LICENSED

The following physicians were granted licenses by either written or oral reciprocity examinations at meetings held by the Wisconsin State Board of Medical Examiners as indicated below:

OCTOBER 23, 1959, ORAL RECIPROCITY

Name	*School of Graduation*	*Year*	*City*
Seay, Margaret J.	Alabama Medical College	1958	Madison

JANUARY 12, 13, 14, 1960, WRITTEN

Gray, James Alan	University of Alberta	1954	Detroit, Mich.

JULY 12, 13, 14, 1960, WRITTEN

Bettenhausen, Jack M.	Northwestern University	1960	Chicago, Ill.
McCarthy, Thomas M.	Marquette University	1959	Scott AFB, Ill.
Olsen, Ward A.	University of Wisconsin	1959	Boston, Mass.

JULY 13, 1960, ORAL RECIPROCITY

Frischknecht, Albert	University of Zuerich	1949	Rochester, Minn.
Luckay, Frank A.	Ohio State University	1959	Milwaukee

OCTOBER 14, 1960, ORAL RECIPROCITY

Chun, Raymond W. M.	Georgetown Medical School	1955	Madison
Heller, Ben Irwin	University of Minnesota	1942	Wood
Kaveggia, Laszlo	University of Budapest	1944	Madison

JANUARY 10, 11, 12, 1961, WRITTEN

Babcock, Steven W.	University of Pennsylvania	1959	Madison

APRIL 14, 1961, ORAL RECIPROCITY

Weber, William J.	University of Michigan	1958	Ann Arbor, Mich.
Woodson, Dan E.	University of Tennessee	1957	Madison

JULY 12, 1961, ORAL RECIPROCITY

Finlayson, Malcolm	Rush Medical College	1942	Madison
Marx, Arnold J.	Chicago Medical School	1960	Madison
Rorke, Joseph F.	University of Pennsylvania	1943	Scottsdale, Ariz.
Walls, David L.	Indiana University	1959	Madison

OCTOBER 20, 1961, ORAL RECIPROCITY

Swissman, Neil	Ohio State University	1960	Milwaukee

JANUARY 10, 1962, ORAL RECIPROCITY

Cardy, James D.	University of Alberta	1940	Milwaukee
Gale, Robert H.	Northwestern University	1960	Madison

APRIL 13, 1962, ORAL RECIPROCITY

Crisp, Norman W., Jr.	Harvard Medical School	1953	Madison

JULY 11, 1962, ORAL RECIPROCITY

Collentine, Marvin E.	University of Iowa	1957	Wood
Zehm, Ansel C.	Marquette University	1946	Northridge, Calif.

JULY 10, 11, 12, 1962, WRITTEN

Magnin, Dean A.	University of Wisconsin	1961	Toledo, Ohio
Merkow, Leonard P.	University of Wisconsin	1962	Pittsburgh, Pa.
Morbeck, Floyd E.	Marquette University	1962	Muskego
O'Leary, William J., Jr.	Marquette University	1962	Greendale

OCTOBER 26, 1962, ORAL RECIPROCITY

Alford, Gary R.	Indiana University	1961	Madison
Bryant, David G.	New York Medical College	1960	Madison
Gutierrez, Joseph	Marquette University	1961	Milwaukee
Lazarus, Herbert	Tufts University	1955	Wauwatosa
Trush, Charles	University of Wisconsin	1949	Kalispell, Mont.

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
JANUARY 8, 9, 10, 1963, WRITTEN			
Howard, Dennis R.	University of Wisconsin	1962	Madison
JANUARY 9, 1963, ORAL RECIPROCITY			
Kloehn, Ralph A.	Marquette University	1958	Milwaukee
Sawyer, Thomas R.	University of Michigan	1955	Cedar Rapids, Iowa
APRIL 19, 1963, ORAL RECIPROCITY			
Chaney, Martin H.	University of Texas	1960	Madison
JULY 9, 10, 11, 1963, WRITTEN			
Schmitt, Robert L.	University of Wisconsin	1962	Juneau, Alaska
JULY 10, 1963, ORAL RECIPROCITY			
Berkebile, Dale E., Jr.	Indiana University	1962	Marshfield
Brende, Joel O.	University of Minnesota	1956	St. Croix Falls
Gibbons, Austin J.	University of Illinois	1962	Milwaukee
Mathews, Richard J.	Marquette University	1962	Shorewood
Schade, Stanley G.	Yale University	1961	Madison
Updike, Stuart J.	University of Rochester	1962	Madison
OCTOBER 18, 1963, ORAL RECIPROCITY			
Feierabend, Theodore C.	Washington University	1951	Madison
Flores, Raul E.	Havana University	1948	Jackson, Miss.
Orlow, Walter O.	Ohio State University	1955	River Falls
Rich, Frederick	University of Iowa	1950	Madison
Russell, James G.	University of Illinois	1962	Milwaukee
Tregoning, Paul C.	Temple University	1960	Janesville

RECENT WISCONSIN LICENTIATES

JANUARY 15, 1964, ORAL RECIPROCITY

Name	*School of Graduation*	*Year*	*City*
Bard, James W.	Marquette University	1958	Rochester, Minn.
Boyle, Carroll L.	Indiana University	1952	Poseyville, Ind.
Diaz-Esquivel, Jose	University of Madrid	1959	Milwaukee
Dibble, Phillip A.	University of Wisconsin	1955	Madison
Dietrich, Donald E.	University of Southern Cal.	1951	Duluth, Minn.
Englander, Stanley	Northwestern University	1959	Altus, Okla.
Forsyth, James E.	Northwestern University	1938	Winnebago
Giannattasio, Vincent	Creighton University	1958	Milwaukee
Gluckman, Robert M.	Northwestern University	1945	Evanston, Ill.
Goldberg, Henry M.	Marquette University	1962	Milwaukee
Green, Robert M.	University of New York	1957	Great Neck, N. Y.
Hartz, John W.	Harvard Medical School	1962	Madison
Howard, Thomas K.	Jefferson Medical School	1960	Milwaukee
Hutton, Frederick A.	McGill University	1958	Milwaukee
Jew, Sik Q.	University of Arkansas	1957	Monroe
Johnson, Frank R.	Northwestern University	1947	Hinsdale, Ill.
Larsen, William M.	Dalhousie University	1954	Warren, Pa.
Lauvstad, Walter A.	University of Iowa	1958	Marshfield
Mally, Michael J.	Marquette University	1962	Milwaukee
Mueller, Donald R.	University of Minnesota	1952	Minneapolis, Minn.
Newby, Kenneth G.	University of Illinois	1957	Menasha
Phillips, Thomas A.	University of Birmingham	1942	Tomah
Rightmyer, Eugene R.	Jefferson Medical College	1955	Milwaukee
Rosenbaum, Howard T.	University of New York	1957	Madison
Schwindt, Walter D.	University of Washington	1959	Madison
Silvis, Stephen E.	University of Minnesota	1955	St. Paul, Minn.
Smith, Harlan M.	Northwestern University	1960	Madison
Tang, Thomas Tze-Tung	George Washington University	1958	Madison
Young, Hadley R.	Duke University	1956	Duluth, Minn.

1964 **Wisconsin**

Sept. 9, 16, 23, 30: Marquette University School of Medicine postgraduate course in Current Concepts of Cardiac Disorders, Milwaukee County General Hospital, Milwaukee.

Sept. 12–13: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, in conjunction with Wisconsin Otolaryngological Society, Maxwelton Braes, Bailey's Harbor.

Sept. 19: First of a weekly "grand rounds" by the Department of Surgery, University Hospitals, Madison.

Sept. 20–22: Wisconsin Academy of General Practice, Milwaukee Auditorium and Hotel Schroeder.

Oct. 1: Marquette–Jackson Clinic postgraduate program, Park Motor Inn, Madison.

Oct. 7–9: Wisconsin Nurses Association convention, Hotel Schroeder, Milwaukee.

Oct. 8: State Medical Society Council meeting, SMS headquarters, Madison.

Oct. 8, 15, 22, 29: Marquette University School of Medicine postgraduate course in Everyday Problems of Clinical Neurology, Milwaukee County General Hospital, Milwaukee.

Oct. 9–10: State Medical Society House of Delegates Fall Session, SMS headquarters, Madison.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

Oct. 15–17: American College of Obstetricians and Gynecologists, District VI meeting, Milwaukee.

Nov. 11–12: Fourth annual Milwaukee Medical Conference, Milwaukee County Hospital, Milwaukee.

Nov. 14: Wisconsin Society of Pathologists, annual fall meeting, Marquette University School of Medicine, Milwaukee.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

1965

May 4–6: State Medical Society Annual Meeting, Milwaukee.

1964 **Out-of-State**

Sept. 9–11: 29th annual congress, International College of Surgeons, North American Federation, Chicago.

Sept. 10–11: Symposium on Clinical Applications of Electronics in Cardiovascular Disease, Minnesota Heart Association and Mayo Clinic, Rochester, Minn.

Sept. 15, 1964–June 15, 1965: Nine-month tutorial program in Cardiology, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Sept. 17–18: National conference on voluntary health agencies sponsored by the American Medical Association Council on Voluntary Health Agencies, Drake Hotel, Chicago.

Sept. 17–19: Fifth National Cancer Conference, Philadelphia, Pa.

Sept. 20–26: III World Congress of Anesthesiology-World Federation of Societies of Anesthesiologists, Sao Paulo, Brazil.

Sept. 26–28: 10th Congress of the Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 21–23: Annual continuation course of the Department of Pediatrics, University of Minnesota, Minneapolis.

Sept. 21–25: American College of Physicians postgraduate course: Current Clinical and Laboratory Investigations in the Rheumatic Diseases, Bethesda, Md.

Sept. 21–25: Animal Care Panel, 15th annual meeting, Hilton Hotel, New York City.

Sept. 24–26: American College of Chest Physicians, postgraduate course in electrocardiography in infants and children, Henry Ford Hospital, Detroit.

Sept. 24–26: American College of Obstetricians and Gynecologists, District VIII, Del Coronado Hotel, San Diego, Calif.

Sept. 25–27: ACOG, District II, Hotel Concord, Lake Kiamesha, N. Y.

Sept. 26–27: 24th Annual Congress on Occupational Health, Rice Hotel, Houston, Texas.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Sept. 27–Oct. 2: Flying Physicians Association annual meeting, Palm Springs, Calif.

Sept. 28–30: American College of Chest Physicians, postgraduate course in environmental diseases of the heart and lungs, Pick–Carter Hotel, Cleveland.

Sept. 28–Oct. 10: 10th Congress of the Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Sept. 30–Oct. 2: Florida Diabetes Association, Seminar on diabetes and related endocrine disorders, Balmoral Hotel, Miami Beach, Fla.

Oct. 5–7: University of Colorado School of Medicine, postgraduate course in fractures and dislocations, University of Colorado Medical Center, Denver.

Oct. 5–9: Sixteenth postgraduate assembly of The Endocrine Society, Mayo Clinic, Rochester, Minn.

Oct. 8–9: 16th Annual Conference on the Kidney, sponsored by the National Kidney Disease Foundation, New York Academy of Medicine, New York City.

Oct. 1964–Mar. 1965: Biweekly courses in Continuing Education Program in Psychiatry and Psychotherapy, Mount Sinai Hospital, Chicago, Ill.

Oct. 8–10: American College of Physicians annual fall meeting, Los Angeles, Calif.

Oct. 8–10: Association of American Physicians and Surgeons, New Orleans, La.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Oct. 12–15: University of Cincinnati, symposium in occupational skin problems for physicians, Kettering Laboratory, Cincinnati, Ohio.

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 16–17: Regional Fitness Clinic for eight Midwestern states, sponsored by the President's Council of Physical Fitness and co-sponsored by the State Medical Society of Wisconsin, University of Illinois, Champaign–Urbana.

Oct. 21–22: 18th annual meeting of Council on Arteriosclerosis, American Heart Association, Hotel Shelburne, Atlantic City, N. J.

Oct. 22–24: American College of Gastroenterology annual course in postgraduate gastroenterology, The Roosevelt, New York City.

Oct. 23–25: American Heart Association 37th annual scientific sessions, Convention Hall, Atlantic City, N. J.

Oct. 25: American College of Nutrition annual scientific meeting, New York City.

Oct. 26–29: National Safety Congress, Chicago.

Oct. 26–30: American College of Chest Physicians, postgraduate course in clinical cardiopulmonary physiology, Continental Hotel, Chicago.

Oct. 29–31: First National Congress on Strokes, Palmer House, Chicago.

Nov. 3–7: American Society of Oral Surgeons, 46th annual meeting, Las Vegas, Nev.

Nov. 7–8: National conference on disaster medical care, Chicago.

Nov. 13–16: 1964 annual convention of National Society for Crippled Children and Adults, Statler–Hilton Hotel, Detroit, Mich.

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–18: Section on Otolaryngology of the Southern Medical Association annual meeting, Memphis, Tenn.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

Nov. 29: Sixth National Conference on the Medical Aspects of Sports, Miami Beach, Fla., in conjunction with the Annual Clinical Convention of the American Medical Association, Nov. 29–Dec. 2.

Dec. 14–16: Postgraduate Assembly in Anesthesiology, New York City.

1965

Jan. 25–30: Workshop in Teratology, University of California, Berkeley.

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

1966

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Wisconsin Society of Pathologists

Marquette University School of Medicine, Milwaukee, will be the setting for the annual fall meeting of the Wisconsin Society of Pathologists on Saturday, Nov. 14.

At the morning session, Dr. D. Murray Angevine, professor of pathology, University of Wisconsin Medical School, will discuss "Recent Developments in Collagen Disorders," and scientific papers will be presented by members. The afternoon session will be devoted to a tissue seminar on tumors of the thorax and endocrine organs, moderated by Dr. Lewis B. Woolner, Surgical Pathology Section, The Mayo Clinic, Rochester, Minn. Dinner and the society's business meeting will be held at the Coach House Inn, Milwaukee.

American College of Physicians

The American College of Physicians announces its postgraduate course No. 1, "Current Clinical and Laboratory Investigations in the Rheumatic Diseases," Sept. 21–25 at the National Institutes of Health Clinical Center, Bethesda, Md. Through a series of seminars covering topics in immunology and genetics, followed by panel discussions emphasizing clinical applications, this course will highlight those aspects of fundamental, scientific investigations which bear on clinical problems in rheumatology. A feature will be the availability of optional laboratory visits for demonstrations of new techniques such as immunofluorescence, immunoelectrophoresis, determination of GM groups, and biomechanics which have contributed greatly to knowledge of rheumatic disease processes. Registration forms and requests for information should be sent to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

UW Announces International Cancer Conference

An international conference on treatment of advanced cancers will be held at the University of Wisconsin Aug. 27–29, Dr. Anthony R. Curreri has announced. "As a pioneer and active participant in cancer chemotherapy, the UW Medical Center hosts these conferences to help disseminate more anticancer therapy information," said Doctor Curreri, who is director of the Center's Division of Clinical Oncology.

Built around the theme, "Several Approaches to the Control of Advanced Cancer," the 2½-day conference will be the fourth postgraduate program on cancer chemotherapy sponsored by the division since 1960. Taking part will be 8 distinguished guest speakers from all over the country and 12 UW faculty members. Further studies on two Wisconsin-developed drugs, 5-FU and 5-FUDR, now widely used for advanced cancer treatment, will be presented.

American College of Nutrition

The annual scientific meeting of the American College of Nutrition will be held at the Americana Hotel in New York City on Sunday, Oct. 25. Requests for further information should be directed to Robert A. Peterman, M.D., F.A.C.N., Secretary-Treasurer, 3 Craig Court, Totowa Boro, N. J. 07512.

Flying Physicians

The 10th annual meeting of the Flying Physicians Association will be held at the Riviera Hotel, Palm Springs, Calif., Sept. 27–Oct. 2, according to Dr. J. S. Huebner, Fond du Lac, chairman of the association's Wisconsin chapter. As in past years, Doctor Huebner noted, the continuing theme for the scientific portion of the program will be the over-riding importance of safety as it relates to the operation of private aircraft.

Principal speaker at the association's annual dinner will be Bernt Balchen, who piloted Adm. Richard E. Byrd's "America" during the Atlantic crossing of 1927 and in 1929 became the first man to fly over the South Pole. Among the many distinguished physicians who will address the meeting will be Dr. Herman A. Heise, nationally-known Milwaukee allergist who has made extensive use of his plane doing original research into the relationship between air temperature variations and wind variations on the distribution of pollens and molds in the upper atmosphere. Doctor Heise will speak on "The Effect of Drugs and Alcohol in Aviation."

Postgraduate Assembly in Anesthesiology

Applications for the Scientific Exhibition of the 18th Postgraduate Assembly in Anesthesiology, Dec. 14–16, New York Hilton, Rockefeller Center, New York City, may be secured by writing to Dr. Robert S. Donnenfield, chairman, Scientific Exhibition, New York State Society of Anesthesiologists, 30 East 42nd Street, New York, N. Y.

MILWAUKEE MEDICAL CONFERENCE WILL PURSUE "MEDICAL AND SURGICAL ASPECTS OF TRAUMA" THEME ON NOV. 11–12, 1964

"Medical and Surgical Aspects of Trauma" will be studied at the 4th annual Milwaukee Medical Conference. The Conference will be held at the Coffey Memorial Auditorium of Milwaukee County Hospital Wednesday, Nov. 11, and Thursday, Nov. 12, 1964. The meeting is open to all physicians.

The Milwaukee Medical Conference is sponsored by The Medical Society of Milwaukee County in cooperation with other medical groups and Milwaukee area hospitals. A meeting of the American College of Surgeons Section VI Committee on Trauma will be held in conjunction with the conference. The committee meeting will be held at 12:15 p.m. Thursday, Nov. 12, at Milwaukee County Hospital.

Conference participants are invited to attend a program on the management of specific injuries which will be presented by the Milwaukee County Intern-Resident Association, also a co-sponsor of the Conference. This program will be held at Milwaukee County Hospital beginning at 9 a.m. on Wednesday, Nov. 11. There is no registration fee for this part of the conference.

The registration fee for the conference is $5. There is no fee for interns, residents and students.

Guest faculty members include Drs. Robert A. Kennedy, Director, Field Program Committee on Trauma, American College of Surgeons, New York City; Lt. Col. John A. Moncrief, Commanding Officer and Director, U. S. Army Surgical Research Unit, Brooke Army Medical Center, Ft. Sam Houston, Texas; Mark Nickerson, Professor and Chairman, Department of Pharmacology, University of Manitoba, Winnipeg, Manitoba, Can.; and Thomas Shires, Professor and Chairman, Department of Surgery, The University of Texas Southwestern Medical School, Dallas.

In announcing the program, Dr. Leonard W. Worman, 1964 Milwaukee Medical Conference Planning Committee Chairman, said:

"In keeping with tradition, the fourth annual Milwaukee Medical Conference will bring together a group of well-known scientists to familiarize the physician with the latest concepts of an important topic of general interest.

"Trauma is a leading cause of death for age groups 1–35, the most productive years. The modern physician has at his disposal the means to decrease mortality and allay morbidity. The initial care of the trauma victim lies within the competence of every physician. It is essential to the well-being of the community that he develop and maintain these skills."

Doctor Worman is assistant professor of Thoracic and cardiovascular surgery at Marquette University School of Medicine, and director of emergency services at Milwaukee County Hospital.

The opening session of the Conference on Wednesday afternoon will develop the role of the physician in the initial care of the trauma victim, covering such topics as the airway-endoctracheal tube vs. tracheostomy, drug and fluid therapy in the emergency room, and monitoring the resuscitative efforts.

On Thursday morning, Nov. 12, the Conference program will cover the continued care of the trauma patient. Maintenance of renal function, use of vasodilators, electrolyte and water requirements are among the topics to be presented.

The second session beginning at 11:15 a.m. on Thursday will feature discussions on the emergency room and its functions as a community health facility. Hospital administrators and nurses are especially invited to attend this portion of the program.

Special care of the trauma patient will be covered on Thursday afternoon, beginning at 1:30 p.m. Among the subjects to be discussed are burns, a special session on the injured child, and the physiology of acute pericardial tamponade.

Each session of the conference will include a discussion period with audience participation.

Inquiries should be addressed to: 1964 Milwaukee Medical Conference, The Medical Society of Milwaukee County, 756 N. Milwaukee St., Milwaukee, Wis. 53202.

Marquette Course: Cardiac Disorders

Marquette University School of Medicine in cooperation with Milwaukee County General Hospital announces a postgraduate course in Current Concepts of Cardiac Disorders. The course will be held on four Wednesday evenings, 7:30 to 9:30, on Sept. 9, 16, 23 and 30, at the King Conference Room, Milwaukee County General Hospital 8700 West Wisconsin Ave., Milwaukee.

Guest speaker will be James V. Warren, M.D., professor and chairman, Department of Medicine, Ohio State University School of Medicine, Columbus, Ohio.

Director of the course is Ramon L. Lange, M.D., associate professor of medicine, Head Cardiovascular Section, Marquette University School of Medicine.

The American Academy of General Practice will grant eight hours of Category I credit. Tuition is $25 (no charge to residents, interns, or medical students). Reservations should be made with Joseph W. Rastetter, M.D., Director Postgraduate Medical Education Programs, 8700 West Wisconsin Ave., Milwaukee, Wis. 53226.

Marquette Course: Clinical Neurology

A postgraduate course, similar to the one mentioned above, will be held October 8, 15, 22, and 29 and will feature Everyday Problems of Clinical Neurology. Reservations can be made as above. Tuition and AAGP credit are also the same.

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turned
hypertensive

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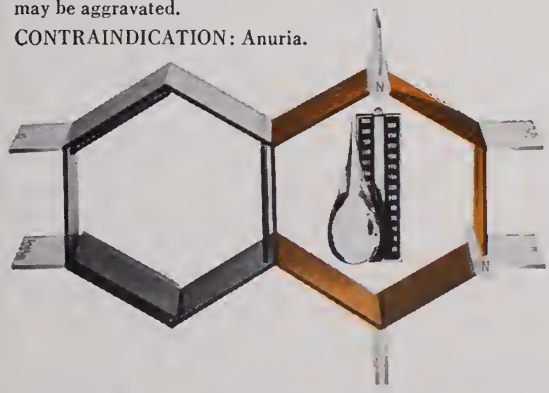

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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U. of W. PROGRAMS for 1964-1965 ANNOUNCED

(in cooperation with the CES Foundation)

The University of Wisconsin Medical School announces a continuation of the one-day "In Depth" programs, so well received in 1963–1964, supplemented by several longer courses in surgery, hospital administration, and pediatrics. The schedule for the "In Depth" programs is as follows:

Thursday, October 29

Dermatology and Allergy: "Eczemas and Related Diseases"

Wednesday, December 9

Pediatrics: "The Management of Common Childhood Anemias"

Thursday, January 28

Surgery: "Colon and Rectal Surgery in Children and Adults

Wednesday, February 17

Orthopedics: "Congenital Hips and Foot Deformities in Children"

Thursday, March 18

Obstetrics and Gynecology: "Endocrine Problems in Gynecology"

Subjects have been selected which will lend themselves to patient demonstrations, and each meeting will begin with a "wet clinic" in Room 300 of University Hospitals at 10:00 a.m., followed by luncheon and discussions at the State Medical Society, 330 East Lakeside Street.

These programs, planned cooperatively with the Madison Chapter of the Wisconsin Academy of General Practice, provide 5 hours of educational credit for all A.A.G.P. members in attendance. However, **the programs are open to all licensed physicians** (MD degree); and members of the State Medical Society are urged to reserve these dates and attend the instructional programs. The fee of $5.00 covers the luncheon and special parking at University Hospitals for the morning meetings. All other costs are covered by the CES Foundation of the State Medical Society, with supporting funds from the Merck Sharp & Dohme Postgraduate Program.

Those wishing to register in advance will please complete the form below, and mail it with a covering check as indicated.

I plan to attend the programs checked:

$5.00 PER MEETING
(Includes lunch and parking)

Name: _____

Address: _____

City: _____

Oct. 29: Dermatology: ____
Dec. 2: Pediatrics: ____
Jan. 28: Surgery ____
Feb. 17: Orthopedics: ____
March 18: Ob & Gyn: ____

(Make check payable to: CES Foundation)

Mail to: Roy T. Ragatz, Assistant Secretary
State Medical Society of Wis.
Box 1109, Madison, Wis. 53701

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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Journal
Established 1903

Annual Subscription ------$6.00
Single Copy ---------- 1.00
Previous Years' --------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Deorborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage poid at Modison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for moiling ot speciol rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all cammunicotions to THE WISCONSIN MEDICAL JOURNAL, Street oddress: 330 East Lakeside Street. Moiling address: Box 1109, Modison 1, Wisconsin.

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"History is not only that which is hundreds of years old. History is today's events. They should be recorded for the time when they can be evaluated in the light of experience and impartiality."

THANKS

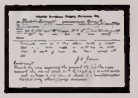
DR. N. A. HILL, Madison, for the commode currently on display in the Council Room of the Society headquarters at Madison.

This "potty" chair, which is approximately 150 years old, was brought into the Madison area by covered wagon, and for about 75 years, it was in the possession of one family here. In 1963, through the good offices of Doctor Hill, it came to the Section on Medical History from the estate of Mrs. William Dowling. Such chairs are collectors' items today, but modern-day counterparts are still used in many areas where indoor plumbing has not as yet been achieved.

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS



MEDICAL MUSEUM

SPECIALTY SOCIETY PROCEEDINGS

Second Annual Statewide Program Presented on Obstetrics and Gynecology

The second annual statewide program on obstetrics and gynecology for the family physician was presented in June by the Wisconsin Section, American College of Obstetricians and Gynecologists, and the Wisconsin Academy of General Practice in cooperation with the Wisconsin State Board of Health, the Wisconsin Maternal Mortality Institute, and Merck Sharp and Dohme. Program chairmen were *Dr. Joseph S. Devitt* and *Dr. Alex Krembs* of Milwaukee. Doctor Devitt is chairman of the board of the Academy and Doctor Krembs is chairman of the Wisconsin Section.

First in the series of programs was that held on June 3 at Madison, where *Dr. R. E. Whitsitt*, Madison, served as panel chairman and was also one of the speakers. *Dr. Everett L. Roley* discussed the topic, "Infertility." *Dr. David V. Foley*, clinical instructor, Marquette University School of Medicine, spoke on "Family Control" at the Madison meeting and also at the programs on June 4 at Eau Claire and June 5 at Green Bay.

"Diagnostic Aids in Hormonal Therapy" was Doctor Whitsitt's subject at the Madison meeting, and the same topic was presented at the Eau Claire and Green Bay programs by *Dr. Richard Mattingly*, professor and chairman, Department of Obstetrics and Gynecology, Marquette University School of Medicine.

Appearing on all three programs were Dr. H. Close Hesseltine, professor of obstetrics and gynecology, University of Chicago School of Medicine, "Elimination of Therapeutic Failures in Vaginal Discharge," and Dr. Buford Word, assistant professor of obstetrics and gynecology, University of Alabama, "Pitfalls of Uterine Curettage."

Dr. Walter O. Paulson, Eau Claire, spoke on "Infertility" and served as panel chairman at the Eau Claire meeting, and *Dr. George Theiler*, Green Bay, fulfilled the same role at the Green Bay meeting.

Program arrangements were in charge of *Dr. Russell F. Lewis*, Marshfield; *Dr. Thomas F. Heighway*, Middleton; *Dr. Guy G. Giffen*, Eau Claire; and *Dr. Wallace MacMullen*, Green Bay.

Dr. W. B. Hildebrand New President of Wisconsin Heart Association

Dr. William B. Hildebrand, Menasha, was installed as president of the Wisconsin Heart Association at its 16th annual meeting in June at the Wisconsin Center, Madison. He succeeds *Dr. Charles W. Crumpton* of Madison.

Doctor Hildebrand has served as a board member of the association for several years, and was state campaign chairman for the 1961 and 1963 Heart Fund drives.

James T. Harrington, Wauwatosa, was named president-elect; and Robert A. Sanderson, Milwaukee, secretary-treasurer. New board members include *Dr. John Rankin*, Madison.

The meeting honored campaign workers and included symposiums on cardiovascular diseases for physicians, external heart massage for nurses, and association programs for lay leaders.

Addressing an audience of some 250 physicians, nurses, and volunteer leaders, *Dr. Edgar End*, Milwaukee, said that discoveries made in deep-sea diving are helping physicians treat carbon monoxide poisoning, gangrene, and coronaries. Doctor End, who is assistant clinical professor of occupational and environmental medicine at Marquette University, told the group that use of helium and oxygen to eliminate the narcotic effect of decompression on divers has led to the use of oxygen under pressure in other medical areas.

The newly-developed Gott–Daggett artificial heart valve was displayed, and its development and surgical application were described by its co-developer, *Dr. Vincent L. Gott*, associate professor of surgery at the University of Wisconsin Medical School.

Speakers at the morning session for nurses included Mrs. Mignon Ritchie, Utah Heart Association program director; W. Wade Boardman, Madison attorney; and *Dr. Robert L. Chancey*, Beloit.

Board of Health Reelects Dr. Clark

The reelection of *Dr. William T. Clark*, Janesville, as president of the State Board of Health was announced in July by *Dr. Carl N. Neupert*, state health officer. Doctor Clark has served as president of the Board since 1960. Also reelected was *Dr. Edward N. Vig*, Viroqua, vice-president.

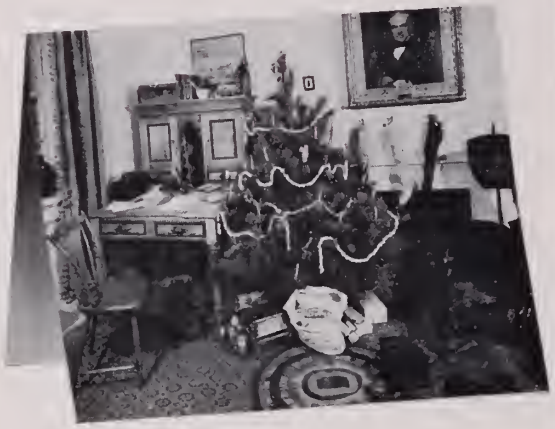
Ozaukee–Sheboygan County Medical Assistants

Mrs. Eleanor Schaut, optician at the Sheboygan Clinic, was installed as president of the Ozaukee–Sheboygan County Medical Assistants Society at its annual installation banquet in June at Fox Hills Country Club, Mishicot.

Mrs. Luella Hoffman, who is employed by *Dr. H. J. Hansen* of Sheboygan Falls, is the society's new president-elect. Others installed were Miss Sojan Dittrirh, secretary to *Dr. Paul P. Bassewitz*, Sheboygan, treasurer; Miss Mary Imig, employee of *Dr. Harold Heinz*, Sheboygan, recording secretary; Mrs. Ceil Schmeckel, secretary at the Sheboygan County Guidance Center, corresponding secretary.

Physicians whose names appear in italics are members of the State Medical Society.

A Unique Christmas Card



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SPECIALTY PROCEEDINGS *continued*

The installation was conducted by Mrs. June Gillette, Sheboygan, past president of the Wisconsin State Medical Assistants Society.

17th Annual Meeting of SMS O and O Section

Glaucoma was the subject of Dr. Paul Chandler, Boston, when he addressed the 77 members in attendance at the 17th annual meeting of the Section of Ophthalmology and Otolaryngology of the State Medical Society in May at the Milwaukee Auditorium. The scientific section was opened by *Dr. William Hilger*, Milwaukee, who spoke on mid-facial injuries.

Dr. Samuel Blankstein, Milwaukee, presided over the meeting, at which numerous committee reports were presented. *Dr. George Nadeau*, Green Bay, announced that the State Section of the Medical Foundation for Eye Care is now affiliated with the national organization. *Dr. Meyer S. Fox*, Milwaukee, emphasized the need for eye banks in his report for the committee on visual and hearing defects. *Dr. John Hitz*, Milwaukee, division of visual handicapped, discussed the feasibility of establishing additional eye banks. *Dr. John Doolittle*, Madison, reported for the fee schedule committee and *Dr. Frederick J. Davis*, Madison, committee on National Medical Foundation for Eye Care, reported on the New York meeting he attended.

Dr. James Bolger, Milwaukee, gave the legislative committee's report and *Dr. Ralph Rank*, Milwaukee, Knights Templar committee, discussed research grants and the eye bank for sight restoration. *Dr. Maxine Bennett*, University Hospitals, Madison, announced the Triological Society meeting to be held Jan. 23–24, 1965, in Madison. *Dr. Robert T. Schmidt*, Green Bay, reported for the committee to study splitting of the O and O section. Doctors Nadeau and Hitz spoke in favor of the Milwaukee O and O society's recommendation to consider a statewide O and O group for legislative educational purposes.

The slate of candidates presented by a nominating committee headed by Doctor Rank was unanimously accepted, with Doctor Schmidt as chairman; *Dr. Frank Treskow*, Milwaukee, delegate; Doctor Doolittle, alternate delegate; and *Dr. Clemens Kirchgeorg*, Neenah, secretary. Serving with Doctor Rank were *Drs. William Randolph*, Manitowoc, and *John Berger*, Madison.

Annual Rock County Play Day

The Hon. Henry C. Schadeberg, member of the House of Representatives from District 1, spoke before some 200 doctors, dentists, and pharmacists of Rock County and their wives in mid-June at the Janesville Country Club. His subject was national legislation, with special emphasis on Kerr–Mills and related subjects. The joint meeting of the three groups is a yearly event known as the Annual Rock County Play Day for Doctors, Dentists and Pharmacists.

Dr. Hildebrand Speaks Against Medicare

Reasons for the opposition of physicians of the country to the King–Anderson medicare bill were put forth by *Dr. William B. Hildebrand,* Menasha, at a meeting of the Fond du Lac Rotary Club in June. Doctor Hildebrand called the bill the work of "vote getters and power-hungry bureaucrats and crusaders in Washington.

Students Hear Dr. Tenney

"Love them and leave them be." That is the attitude parents should take toward their children, according to *Dr. H. Kent Tenney, Jr.,* professor emeritus of pediatrics at the University of Wisconsin. Doctor Tenney addressed about 200 university students at the Memorial Union in Madison in the second of a series on "The Contemporary Scene."

Iowa Professor Speaks at Marshfield Clinic

"News in Cytogenetics," dealing with the subject of inheritance and inheritance factors, was the topic of Dr. Hans Zellweger, professor of pediatrics at the State University of Iowa, when he addressed a scientific meeting at the Marshfield Clinic library sponsored by the Marshfield Clinic Foundation. He was introduced by *Dr. Gerald Porter* of the clinic staff. Some 40 physicians heard the address given by the Iowa professor, who is presently engaged in the study of mongolism and other congenital conditions.

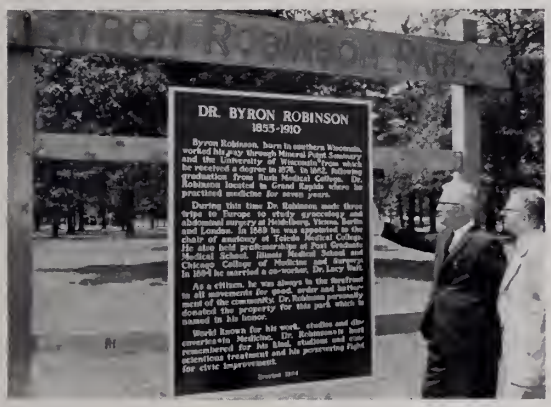

Photo courtesy WISCONSIN RAPIDS DAILY TRIBUNE

Inspecting the new Robinson historical marker are Dr. Leland Pomoinville and Marshall Beuhler of the South Wood County Historical Corp.

Marker in Park Honoring Dr. Byron Robinson Is Gift of Dr. L. C. Pomainville

A financial gift from *Dr. Leland C. Pomainville* of Wisconsin Rapids has made possible the historical marker honoring the late Dr. Byron Robinson which was recently erected in Robinson Park, Wisconsin Rapids. The marker was sponsored by the South Wood County Historical Corporation, of which Doctor Pomainville is president.

Physicians whose names appear in italic are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

A noted physician and medical researcher who was author of eight medical books and is mentioned 52 times in GRAY'S ANATOMY, Doctor Robinson donated the park property to the city nearly 60 years ago so that it might benefit by his success which had its roots there.

A graduate of the University of Wisconsin and of Rush Medical College, he located in Grand Rapids (now Wisconsin Rapids) and practiced medicine there for seven years. During this time Doctor Robinson made three trips to Europe to study gynecology and abdominal surgery at Heidelberg, Vienna, Berlin, and London. In 1889 he was appointed to the chair of anatomy at Toledo Medical College. He also held professorships at Post Graduate Medical School, Illinois Medical School, and Chicago College of Medicine and Surgery.

Dr. Bergmann Joins Marsh Clinic

Dr. Franklyn T. Bergmann has joined the staff of the Marsh Clinic in Shawano. A 1960 graduate of the University of Wisconsin Medical School, Doctor Bergmann interned at Mercy Hospital, Toledo, Ohio. During the three years prior to his acceptance of the post at Shawano, he served in the U. S. Air Force.

Dr. Peters Appointed to Marquette Board

Dr. Bruno J. Peters, medical director of the Allen–Bradley Company, and an associate clinical professor of medicine at the Marquette University School of Medicine, Milwaukee, has been appointed to the school's board of directors. Doctor Peters was graduated from the medical school in 1938.

Dr. Graf Joins Urology Clinic

Dr. R. A. Graf, 1956 graduate of the University of Wisconsin Medical School, has joined *Dr. A. P. Schoenenberger* and *Dr. J. F. McIntosh* at the Urology Clinic in Madison. Doctor Graf served his postgraduate residency in urology at State University of Iowa Hospitals, Iowa City, from 1959 to 1964.

Dr. Regehr Opens Practice In Athens

Dr. Edward H. Regehr, physician and surgeon, started practicing in July at the Medical Center in Athens, which had been without a doctor since June 1963 when *Dr. Mahmood Miroseini* left to join the Medford Clinic staff. A graduate of the University

of Manitoba Medical College, Winnipeg, Canada, Doctor Regehr will be associated with Memorial Hospital of Taylor County, Medford.

Ogema Expecting Doctor from Abroad

Dr. Saifuddin Ahmed, a native of West Pakistan who holds degrees from Punjab University in that country, has agreed to come to Ogema to practice medicine. He is at present the senior medical officer with Attock Oil Company, Limited, located in Rawalpindi, West Pakistan, but he has also studied and practiced in England and Scotland for 10 years, and at one time he was Chief Resident of Medicine at City Hospital, Elmhurst, N. Y.

X-Ray Precautions Dr. Mauthe's Topic

Dr. Howard Mauthe dispelled some misconceptions when he addressed the Fond du Lac Rotary Club in July. A Rotarian himself, the Fond du Lac physician explained the safety precautions and Doctor Mauthe is head of the department of radiation at St. Agnes Hospital, Fond du Lac.

Dr. White Returns to State

Following eight years as superintendent and medical director of District State Sanatorium, Harlingen, Texas, *Dr. Ellison White* has returned to Wisconsin to accept the medical directorship at Southern Colony and Training School in Union Grove. Prior to leaving for Texas, Doctor White was superintendent and medical director of Wisconsin State Sanatorium in Wales from 1950 to 1955. From 1948 to 1950 he was employed in the same capacity at Middle River Sanatorium, Hawthorne. Doctor White came to this state in 1948 from Seattle, Wash., where he had served as staff physician at Firland Sanatorium.

Mayo Foundation Residents Locate in State

Four residents at the Mayo Foundation in Rochester, Minn., have left that city to locate in Wisconsin. They are: Dr. J. C. Payne, resident in psychiatry, who has located in Oshkosh; Dr. F. L. Hildebrand, internal medicine, now located in Menasha; Dr. J. D. Grabow, neurology, to Madison; and Dr. R. L. von Heimburg, surgery, now at Green Bay.

Rapid Cancer Detection Method Found

Automation may aid in the rapid screening of large numbers of women for cervical cancer, according to *Dr. Ben M. Peckham*, professor of obstetrics and Gynecology at the University of Wisconsin Medical School.

A rapid method of detecting malignancies, developed by Doctor Peckham and Judith B. Ladinsky, UW project assistant in obstetrics and gynecology, is based on the fact that cancer cells are larger than normal cells in the cervix. The automated system operates on the principle that larger cells offer more resistance to electric current passing through them. One instrument, called a Coulter counter, measures the amount of current flowing through samples of cells in vaginal washings. This in turn is recorded on a graph by another instrument.

Dr. Allen Joins Clinic Staff

Dr. William Allen has joined the staff of the Garrison-Handy Clinic at Wisconsin Rapids. After receiving his M.D. degree in 1957 from Ohio State University, Doctor Allen interned at Ohio Valley General Hospital in Wheeling, W. Va., and then practiced for a year in Cadiz, Ohio. A veteran of two years of service as a medical officer in the Air Force, stationed in Turkey, Doctor Allen has just completed a three-year residency in internal medicine at Maumee Valley Hospital, Toledo, Ohio.

He is co-author of a paper, "The Effects of Hyperbaric Oxygen on Myocardial Infarction," which is to be presented in September at the Surgical Forum in Chicago.

New Appointees at Oconomowoc Hospital

The board of directors of Memorial Hospital, Oconomowoc, has announced the appointment of *Dr. Owen E. Miller*, Milwaukee, orthopedic surgeon, to the medical consulting staff, and *Dr. John J. O'Hara*, Oconomowoc, to the courtesy staff. Doctor Miller will be associated with *Drs. Alfred E. Kritter* and *Charles A. Desch* of Waukesha. Doctor O'Hara is an associate of Rogers Memorial Hospital, practicing in general practice and psychiatry.

Dr. Hildebrand Joins Riverside Clinic

Riverside Clinic in Menasha has announced the addition to its staff of Dr. Fredric L. Hildebrand, specialist in internal medicine and the son of *Dr.* and Mrs. *William B. Hildebrand* of Menasha. Following his graduation in 1960 from the University of Pennsylvania Medical School, Doctor Hildebrand interned in 1961 at Minneapolis General Hospital, and during 1961 through 1964 he was a fellow in internal medicine at the Mayo Clinic and Mayo Foundation in Rochester, Minn. He and his wife and four children will reside in Neenah.

Gundersen Clinic Adds Three to Staff

Officials of Gundersen Clinic, Ltd. and the La Crosse Lutheran Hospital have announced the association of three new physicians: Drs. Robert M. Green, William A. Morgan, and Charles H. Bruce.

After receiving his M.D. degree in 1957 from the State University of New York, Downstate Medical Center, New York City, Doctor Green interned at Montefiore Hospital where he also served his first year of residency in internal medicine. Following his second year of residency, spent at the Kingsbridge VA Hospital, he served two years as an internist in the United States Army and then was awarded a one-year fellowship in 1962 at Montefiore Hospital by the New York Heart Association. In

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1963 he was awarded a fellowship in cardiology, also at Montefiore, by the National Institutes of Health. He is certified by the American Board of Internal Medicine.

Doctor Morgan interned at New York Hospital after receiving his degree in 1956 from Cornell University Medical College, New York City. He served three years in the Army at Heidelberg, Germany. He has spent four years in residency in internal medicine, the first year at Stanford Medical Center, Palo Alto, Calif., the second two at New York Hospital, and this last year at Stanford Medical Center as chief resident in internal medicine.

Doctor Bruce holds an M.D. degree from the University of Georgia School of Medicine, Augusta, Ga. He served his internship at Baylor University Hospital, Dallas, Texas, and completed a four-year residency in obstetrics and gynecology at the same hospital. A veteran of one-and-a-half years of Army service, Doctor Bruce is a member of the American College of Obstetricians and Gynecologists and is a diplomate of the American Board, a certified specialist in obstetrics and gynecology. He has been in private practice for the last 10 years in Dallas.

Bobath Institute Held

Instructors at the Bobath Institute held July 13 through August 17 at the Kiwanis Children's Center of the Curative Workshop of Milwaukee included (left to right) Dr. E. Richard Blonsky, instructor, Department of Neurology and Psychiatry, Northwestern University Medical School; Dr. Clement A. Fox, professor of anatomy, Marquette University School of Medicine; Dr. Andrew E. Cyrus, Jr., assistant professor, Department of Neuropathology, Marquette University School of Medicine; and Mrs. Lelia Green, R.P.T.. supervisor of physical therapy at Kiwanis Children's Center, Curative Workshop of Milwaukee.

Dr. Karel Bobath and his wife, Berta, head the Western Cerebral Palsey Centre in London. The Bobaths have conducted institutes in this country in Seattle, at Stanford University, and last year at the Wisconsin Central Colony. Mrs. Green worked with the Bobaths in 1959 at the Western Cerebral Palsey Centre in London. Last April and May she worked with them at the Institute held at Central Wisconsin Colony and Training School. Mrs. Green has just returned from six weeks further training and work with the Bobaths at their London clinic.

Edgerton Hospital Sponsors Clinical Program

Dr. Mitchell J. Nechtow, noted Chicago gynecologist, was guest speaker for the first clinical program sponsored by the Memorial Community Hospital medical staff on June 10 at the Towne Country Club, Edgerton. Following a question and answer period, a short film was presented on "Ligation of the Internal Iliac Arteries." *Dr. David A. Cohen*, Edgerton, was in charge of general arrangements and *Dr. T. M. Shearer*, Edgerton, of the program. In addition to the Edgerton and Milton-Milton Junction physicians, there were doctors present from Beloit, Janesville, Columbus, and Fort Atkinson. Doctor Nechtow, whose subject was "Pitfalls in Gynecological Diagnosis," is co-author of three books and author of 80 scientific papers on gynecologic subjects.

Dr. Reeb Awarded Fellowship in Pediatrics

Dr. Kenneth G. Reeb of Madison is one of 15 physicians who have been awarded two-year residency fellowships in pediatrics by Wyeth Laboratories. He will study at the University of Minnesota Hospitals. Graduate physicians apply for the fellowships, which are sponsored by the Wyeth Fund for Postgraduate Medical Education and provide $4,800 over a period of two years starting July 1, to help finance advanced study in the care and treatment of children.

Dr. Woods Elected Lakeland's Head

Dr. William C. Woods, Delavan physician and surgeon, was elected to succeed *Dr. Joseph Schrock*, Sharon, as chief of staff at a meeting of the Lakeland Hospital medical staff July 1 at Delavan. Doctor Schrock was elected to the executive committee and *Dr. Henry Mol*, Elkhorn, was elected vice-chief of staff. *Dr. Harold Werbel*, Delavan, is secretary-treasurer. Doctor Woods, a past president of the Walworth County Medical Society, had been vice-chief of staff the last two years and a member of the executive committee for the past four years.

100 Colleagues Honor Dr. Meyer

Dr. Ovid O. Meyer was honored by nearly a hundred of his friends and associates June 30 at a banquet at the Madison Club. Chairman of the UW Department of Medicine for some 20 years, Doctor Meyer has decided to relinquish his administrative duties, but he will remain as a teacher and researcher at the university.

Every UW Medical School staff member in Madison attended the banquet and everyone had substantially the same comment: Doctor Meyer is a doctor in every laudatory sense of the word. The staff presented him with a captain's chair bearing a plaque with his name.

"He only takes credit for the things he has done; when someone else does something, he gives the other doctor full credit," said *Dr. Robin Allin*. "That's what makes him a good administrator."

2nd Annual Prairie du Chien Seminar

For both attending physicians and their wives (although separately), tours of the Museum of Medical Progress and Stovall Hall of Health were on the agenda for the second annual Prairie du Chien Medical Seminar Aug. 13, sponsored by the Crawford County Medical Society.

Golf for those so inclined started off the day for the doctors, with the museum tour following. While their wives enjoyed tea, tours of the museum and Villa Louis and/or bridge, the physicians heard addresses by *Dr. Frank C. Stiles* of the Monroe Clinic and *Dr. Charles W. Crumpton* of the University of Wisconsin Medical School.

At 5 p.m., the doctors and their wives boarded the paddle wheeler "Prairie Gal" for a two-hour cruise along the Mississippi. At Indian Isle, a privately-owned island in the middle of the river, the group enjoyed an elegant dinner at 7 p.m.

Cairo Psychiatrist Directs County Staff

Dr. Ezzeldin M. (Dean) Salama, Wauwatosa, has started to organize a staff to operate the long-sought children's residential service unit at the Milwaukee County Mental Health Center. Up to 21 children with severe mental problems will be handled in the unit located at Milwaukee County General Hospital.

Doctor Salama comes from Cairo, where he obtained his medical degree in 1951 and served his two years of residency in internal medicine. He did postgraduate work while employed for three years as a registrar at Barnet Hospital in London, going from there to the University of Edinburgh in Scotland where he obtained his MRCP (Member of Royal College of Physicians) degree. In 1959 he went to Traverse City, Mich., where he spent three years as a resident physician at the state hospital. For the last two years, he has been a resident child psychiatrist at Lafayette Clinic in Detroit.

Dr. Otterson Leaves Westby

Dr. Warren N. Otterson and his family have left Westby for Tacoma, Wash., where Doctor Otterson has entered Madigan General Hospital for special training in obstetrics and gynecology. Prior to his departure from Westby, he was associated with *Dr. P. T. Bland* in the medical clinic in Westby.

Dr. Kamstra Now at Monroe Clinic

New to the department of psychiatry at the Monroe Clinic is *Dr. Egbert Kamstra*, a native of The Netherlands, where he graduated in 1954 from State University Groningen.

Doctor Kamstra, who came to Saskatchewan, Canada, in 1957, completed his psychiatric residencies between the University Hospital, the MacNeill Clinic in Saskatoon, and the Provincial Hospital in North Battleford. In 1963, he and his family moved to Michigan's Upper Peninsula, where he became chief of the admission and intensive treatment center of the Newberry State Hospital.

Photo courtesy of NEW RICHMOND NEWS

SISTER OLIVIA (left) discusses the program on care of the newborn in which Dr. Thomas V. Geppert and Sister M. Christopher, both of Madison, took part on June 9 at Holy Family Hospital, New Richmond. Illustrative of the extreme interest she takes in her work is Sister Olivia's recent act of successfully carrying through the smallest baby ever born at Holy Family Hospital, a two-pound infant delivered three months prematurely, smallest ever born to live in the New Richmond area.

Newborn Teaching Conference

Holy Family Hospital, New Richmond, was the setting for one of seven teaching conferences for nurses and physicians on "Care of the Newborn: Including Prematurity," conducted in April and June under the auspices of the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments, and the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. The programs were presented through the Charitable, Educational and Scientific Foundation, with supporting funds from Mead Johnson Laboratories and the State Board of Health.

Instruction at the morning session, for nurses only, was provided by Sister M. Christopher, nursing instructor and supervisor in obstetrics and care of the newborn at St. Mary's Hospital, Madison, and Miss Helen Callon, hospital nursing consultant in maternal and child health of the State Board of Health.

At the afternoon sessions, directed primarily to physicians, *Dr. Thomas V. Geppert*, assistant clinical professor of pediatrics at the University of Wisconsin Medical School, served as instructor.

More than 70 doctors and nurses attended the one-day workshop in New Richmond.

Dr. Beran Joins Fort Atkinson Clinic

Dr. Frank V. Beran became associated with Drs. *James C. H. Russell* and *Henry W. Aufderhaar* Aug. 1 at their clinic in Fort Atkinson, after spending the preceding year in residency in surgery at Madison General Hospital. Before that, he had spent two years with the U. S. Public Health Service on an Indian reservation at Winnebago, Neb. He is a 1960 graduate of the State University of Iowa Medical School.

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Dr. Rybak Honored on His Retirement

Dr. Frank Rybak retired July 30 after 23 years of service to Mendota State Hospital. He was presented with the Governor's Service Award by *Dr. Walter Urben*, hospital superintendent, who also read a letter of commendation from Wilbur Schmidt, director of the State Department of Public Welfare.

Dr. Klomberg Assists at State Prison

Dr. Gerald Klomberg, 1960 graduate of Marquette University School of Medicine, is the new part-time physician at the Wisconsin State Prison at Waupun. Doctor Klomberg, now of Beaver Dam, will maintain his practice there while assisting at the prison. He has had a year of internship and three years of residency at Milwaukee County Hospital.

Japanese Kindness Impresses Dr. Hoon

Dr. James R. Hoon, Sheboygan surgeon who recently returned from a medical research trip to Japan, told of the great kindness he experienced there in a presentation before the Lakeshore Kiwanis Club at Sheboygan. Doctor Hoon was in Japan as a guest of the Olympus Optical Company and studied at the Japanese National Research Hospital.

Doctors Leaving Fox Lake

Drs. William H. Snook and *William J. Duxbury* are discontinuing their association with the Fox Lake Medical Center Oct. 1. The announcement of their departure was made at a meeting of the center at which it was also reported that the Sears Foundation in Chicago had been contacted for assistance in replacing the physicians. The State Medical Society's Placement Services is also assisting.

Dr. Fink Entering Colorado University

Dr. Donald W. Fink, who has been in general practice with the St. Croix Falls Clinic for the past five years, is entering the University of Colorado Medical Center at Denver this fall for a three-year advanced study course in radiology.

Dr. Karrmann Joins Manitowoc Clinic

Dr. Paul L. Karrmann, Jr., who finished his residency in obstetrics-gynecology at Milwaukee Hospital in June, has joined the staff of The Manitowoc Clinic at Two Rivers. A 1957 graduate of Marquette University School of Medicine, he served his internship at St. Mary's Hospital, Milwaukee.

Dr. Skemp Joins Skemp Clinic

Dr. Charles A. Skemp has joined the staff of the Skemp Clinic in La Crosse. For two years prior to his association with the clinic he served as chief of the department of urology at the Naval hospital, Camp Pendleton, Calif. A 1957 graduate of Marquette University School of Medicine, he interned at Miller Hospital in St. Paul and then completed a four-year residency in urology at the university of Minnesota.

Dr. Traynor Director at St. Mary's Hill

Dr. Eugene J. Traynor has been named medical director of St. Mary's Hill Hospital, Milwaukee. Doctor Traynor, who received his M.D. degree from Marquette, completed his residency training at the Independence (Iowa) Mental Health Institute.

Portage Clinic Adds Two Doctors

Drs. Frederick H. Bronson and Charles D. Grose nave joined the staff of the Portage Clinc. Doctor Bronson received his M.D. degree from the University of Wisconsin Medical School and interned at Madison General Hospital. Doctor Grose came to Portage from Glasgow Air Force Base, Montana, where he served as chief of the Air Force clinic. He is a graduate of Loyola University School of Medicine, Chicago, and interned at Ogden, Utah.

Dr. Pfeiffer Takes VA Post

After 41 years as a physician and surgeon *Dr. Oliver W. Pfeiffer*, has discontinued his practice in the Woodruff and Manitowish Waters area to become adjudication officer at the Veterans Administration regional office in Milwaukee. Doctor Pfeiffer is a native of Sheboygan Falls, where his father, the late Dr. Charles Pfeiffer, was a prominent physician and surgeon. Two brothers, both deceased, were also physicians and practiced in Racine. From 1927 to 1945 Doctor Pfeiffer was associated with one of his brothers in the Pfeiffer Clinic in Racine.

Dr. Montgomery Locates in Thiensville

Dr. Edwin G. Montgomery, Jr., pediatrician, has opened an office in Thiensville. A 1961 graduate of Marquette University School of Medicine, Doctor Montgomery interned at Milwaukee Hospital and completed his residency in pediatrics in June at Milwaukee Children's Hospital.

Dr. Burandt Associated with Beloit Clinic

Dr. Donald C. Burandt, 1959 graduate of the University of Wisconsin Medical School, is now associated with Beloit Clinic as a pediatrician, according to an announcement by *Dr. William S. Freeman*, clinic chief of staff. He is associated in the clinic's pediatrics department with Doctor Freeman and *Dr. Frank K. Johnson*. Doctor Burandt, who completed his residency at the University of Minnesota Medical Center in 1962, served for two years at the United States Army Hospital at the White Sands Missile Range in New Mexico.

Dr. Slightam Opens Office

Dr. Pierre Slightam has opened an office for general practice in Green Bay. He was formerly associated with the West Side Clinic in that city.

Dr. Gurkow Practicing in Platteville

Dr. Helen J. Gurkow has opened an office in Platteville for the practice of medicine and surgery. Doctor Gurkow, who received her M.D. degree from Marquette, served a year's internship at Madison General Hospital and a year's residency in surgery at the same hospital. She also taught at the University of Wisconsin Medical School. She is a member of the Platteville Memorial Hospital medical staff.

Elroy Has New Medical Center

The new Elroy Medical Center was opened during the summer in Elroy. The $50,000 structure was built for the purpose of attracting an additional physician, or more, in order that the patient load might not fall so heavily on the shoulders of the few men engaged in medicine in the Elroy area: *Dr. Roy B. Balder, Jr.*, Elroy; *Dr. H. P. Baker*, Wonewoc; and *Dr. Thomas E. Boston*, Hillsboro. The clinic contains six examining rooms, three of which are in use by Doctor Balder.

Dr. Stuart Milson at Green Bay

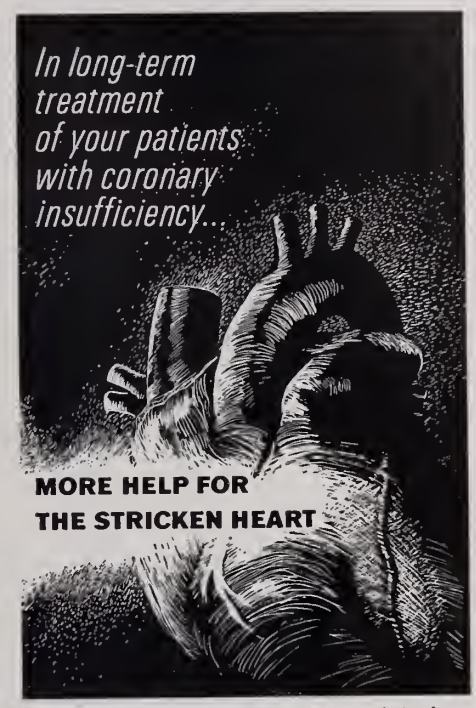
Drs. Louis Milson and *Donel Sullivan* of Green Bay have announced the association of *Dr. Stuart Milson* in the practice of internal medicine. Doctor Milson, who received his doctor of medicine degree from Marquette, joins Doctor Sullivan and his father and brother, Dr. Louis Milson and *Dr. B. I. Milson*, in their offices at Beacon Medical Center. He interned at Ancker Hospital, St. Paul, and took three years of training in internal medicine at Wood Veterans Administration Hospital and Milwaukee County General Hospital.

Dr. Sanford Ends Hillsboro Practice

Dr. L. L. Sanford, a Hillsboro physician and surgeon for nearly 20 years, concluded his practice there July 24 and, with his wife, is now residing in LaFarge. He is on the medical staff of the Vernon Memorial Hospital in Viroqua. An educator during the early years of his career, Doctor Sanford was graduated from the University of Wisconsin Medical School in 1936 and for three years was associated with University Hospitals. He was director of student health at the University of Wyoming from 1939 until 1941, when he became consultant in chest diseases at Muirdale (Milwaukee County) Hospital and Wood Veterans Administration Hospital. From 1958 to 1959 he was assistant chief of the tuberculosis section of the U.S. Veterans Clinic in Pittsburgh, Pa., and later he was an adjudicator of medical pension claims for Veterans Administration pensioners, with offices in Des Moines, Iowa.

Medical Technologists Hear Dr. Nichols

Dr. George Nichols of Appleton spoke on "An Internist Looks at the Laboratory," during the dinner meeting of the Fox River Valley Society of Medical Technologists at the Menasha Hotel in Menasha.



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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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UW Medical School Department Heads, Staff Members Named

Department chairmen for 1964–1965 at the University of Wisconsin Medical School have been announced by Dr. James F. Crow, acting dean. They are:

Drs. Karl L. Siebecker, anesthesiology; *Otto A. Mortensen,* anatomy; *Ben M. Peckham,* gynecology-obstetrics; Klaus Patau, medical genetics; Charles V. Seastone, medical microbiology; Robert F. Schilling, medicine; *Francis M. Forster,* neurology; Harold P. Rusch, oncology; *D. Murray Angevine,* pathology; *Charles C. Lobeck,* pediatrics; *Jack L. Strominger,* pharmacology and toxicology; P. P. Cohen, physiological chemistry; W. B. Youmans, physiology; *A. S. Evans,* preventive medicine; *Milton H. Miller,* psychiatry; *John H. Juhl,* radiology; and *Robert C. Hickey,* surgery.

In addition, *Dr. Anthony R. Curreri* was reappointed director of the Division of Clinical Oncology, and Dr. C. N. Woolsey, director of the Laboratory of Neurophysiology.

New staff appointments at the Medical School include Dr. Jack Grabow, who has joined the Department of Neurology as an assistant professor; Dr. William L. Kopp, who has been an assistant clinical professor of medicine and is now assistant professor; Dr. Robert M. Donaldson, director of the WGH seventh floor metabolic research unit, who joined the Department of Medicine in May as assistant professor; Dr. George Kerr, who has joined pediatrics to work with Dr. H. A. Waisman as an assistant professor; and *Dr. Andrew Crummy,* who will work in diagnostic radiology as an assistant professor.

Other new staff members who received appointments as assistant professors include Drs. Harold E. Booker, neurology; Charles A. Tait, otolaryngology and speech; John Benfield, James Brandenburg, and Donald Wilson, surgery. Appointed to the position of instructor in the Medical School was Dr. George W. Wirtanen, radiology.

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OBITUARIES

Dr. Cyrus L. White, Mineral Point, died Feb. 18, 1964, at the age of 71.

A native of Mineral Point, Doctor White was a 1920 graduate of the University of Illinois College of Medicine and interned at Los Angeles County Hospital. After completing his education, he located in Pittsburg, Kan., before returning to Wisconsin.

Doctor White was a member of the Iowa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a daughter, Mrs. Stuart Crawford, Madison.

Dr. Walter J. K. Clothier, Waukesha, died March 24, 1964, at the age of 65.

Doctor Clothier was a native of Ottawa, Ontario, and was a medical missionary in Africa before coming to New York in 1941. He was a 1926 graduate of the University of Toronto, and interned at Ottawa Civic Hospital. Doctor Clothier served in the Canadian Army during the First World War. He had practiced in Waukesha since 1953.

He was a member and past president of the Waukesha County Medical Society, a member of the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice.

Surviving are his widow, Alice; a son, Dr. Walter J. K. Clothier, Jr., and a daughter, Mrs. George Lapham.

Dr. James H. Fowler, Lancaster, died Mar. 25, 1964, at the age of 94.

Doctor Fowler was born in Union, Ind., and graduated from Rush Medical School, Chicago, in 1902. He came to Lancaster in 1905 and retired from active practice in 1948. Doctor Fowler served in World War I.

Dr. Annette C. Washburne, Madison, died Mar. 27, 1964, at the age of 65.

Originally from Chicago, Doctor Washburne received her medical education from the University of Illinois Medical School in 1929. She served her internship and residency at Wisconsin General Hospital, Madison, and was head of the Neuro-Psychiatry Division at the University of Wisconsin General Hospital before entering private practice in 1953.

Certified by the American Board of Psychiatry, Doctor Washburne was a member of the American Psychiatric Association, the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

She is survived by a brother, Gratiot, DuBois, Wyo.

Dr. Richard M. Rogers, Milwaukee, died Mar. 30, 1964, at the age of 65.

Doctor Rogers was a 1921 graduate of the Columbia College of Physicians and Surgeons, New York. Following internship at Newark City Hospital, Newark, N. J., Doctor Rogers practiced in Newark until he entered the Medical Corps in 1942. He came to Wisconsin in 1945 after his discharge from service.

Dr. John L. Garvey, Milwaukee neurologist, died Mar. 31, 1964, at the age of 69.

A native of Oconto, Doctor Garvey was graduated from the University of Michigan School of Medicine, Ann Arbor, in 1920 and served his internship and residency there. Later he became an associate professor of neurology at the university.

In 1929 he came to Milwaukee to establish a private practice in neuropsychiatry. He gave much of his time to building up the Marquette University School of Medicine, as a clinical professor of neurology and as director of the Division of Neurology.

Doctor Garvey was a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American College of Physicians and the American Academy of Neurology, a past president of the Milwaukee Academy of Medicine, the Milwaukee Neuropsychiatric Society, and the Milwaukee Surgical Society, and a member of numerous other medical groups including The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He also served as an area consultant in neurology for the Veterans Administration Hospital at Wood and as an active staff member of several Milwaukee hospitals. He was chief of staff at Columbia Hospital from 1952 through 1958.

He is survived by his widow, Catherine.

Dr. George B. Wiles, Sheboygan, died Apr. 6, 1964, at the age of 78.

He was a graduate of Northwestern University Medical School in 1908 and served his internship in Lansing, Mich. After completion of his education, Doctor Wiles located in Sheboygan where he practiced until his retirement in 1960.

Dr. Peter E. Oberbreckling, 63, Milwaukee, died Apr. 11, 1964.

Born in Luxemburg, Iowa, Doctor Oberbreckling received his medical education from the Marquette University School of Medicine in 1927 and interned at St. Mary's Hospital, Milwaukee. After completion of his education, Doctor Oberbreckling located in Milwaukee, where he was continuously engaged in practice.

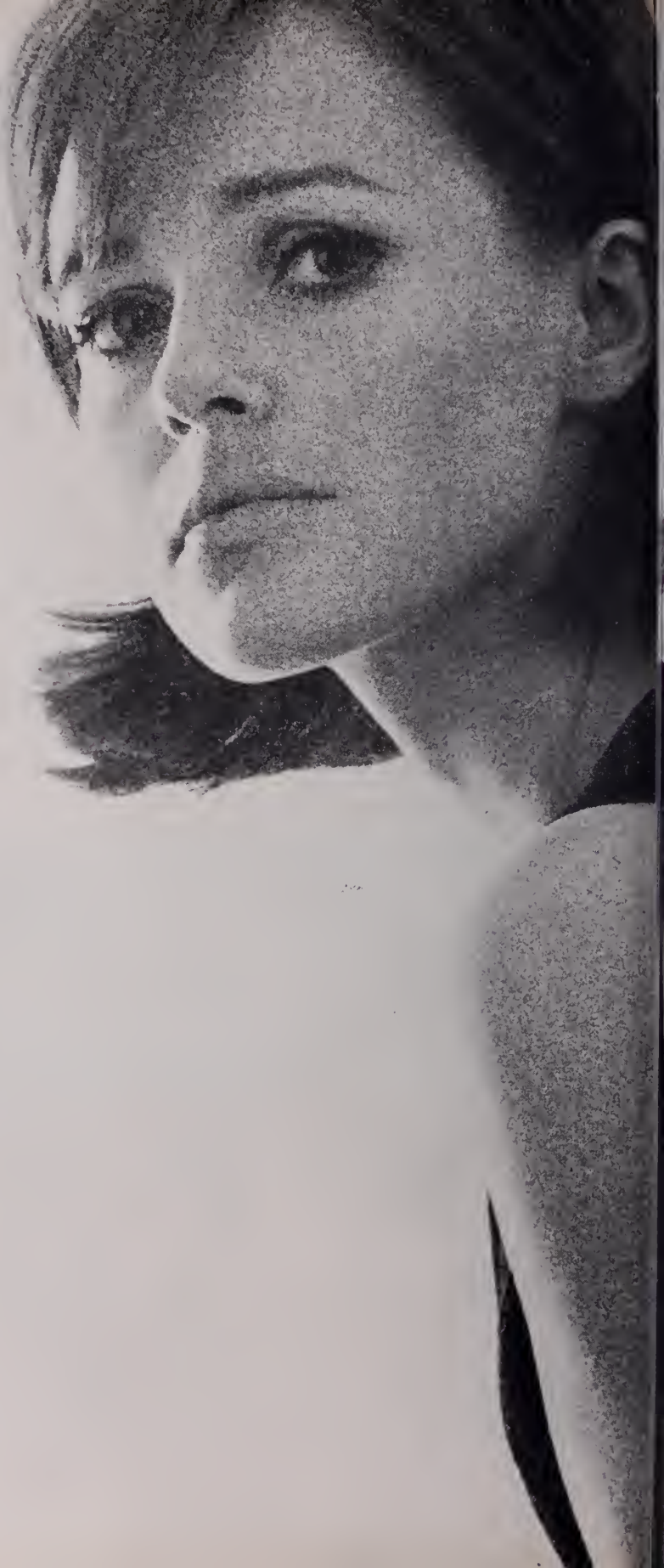
He was a member of the American Geriatric Society, the American Academy of General Practice, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Alma; and four sons, Doctor Paul, Glendale; Doctor Ralph, Oconomowoc; Donald and James, both of Milwaukee.

Dr. Otto F. Dierker, retired Watertown physician, died Apr. 16, 1964, at the age of 82.

Born in Sweet Springs, Mo., Doctor Dierker received his medical education from the University of

too young to be so tired...



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Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
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Nicotinamide	(5 MDR*)	50 mg.
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†Requirement in human nutrition not yet established

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Louisville, Ky., in 1905, and practiced in Kansas and Nebraska before coming to Wisconsin.

He was a member of the Jefferson County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was also president of the board of St. Mary's Hospital in Watertown, where he helped organize the first staff.

He is survived by his widow, Lillian; two daughters, Mrs. H. G. Mallow, Phoenix, Ariz., and Mrs. Louis Tetzlaff, Watertown; three sons, Clarence, Phoenix; Roland F., Watertown; and Capt. W. M., USN, San Francisco.

Dr. Bruno A. Lungmus, Milwaukee, died May 3, 1964, at the age of 73.

Born in Germany, Doctor Lungmus attended medical school in London before coming to the United States shortly before World War I.

He was graduated from the University of Illinois Medical School in 1916 and interned in St. Mary's Hospital, Milwaukee. Doctor Lungmus was assistant surgeon for the United States Steel Company before serving in the Medical Corps in World War I. After the war, he was medical officer for the Veterans Administration prior to entering private practice in Milwaukee in 1929.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Martha; a son, John B., Northfield, Ill.; and a daughter, Dorothy, Cleveland, Ohio.

Dr. Alexander Dwight Spooner, Milwaukee, died May 7, 1964, at the age of 61.

A native of Iowa, Doctor Spooner was a 1928 graduate of the University of Wisconsin Medical School. He interned at St. Mary's Hospital, Madison, and served his residency at Wisconsin General Hospital, Madison, and the Mayo Clinic, Rochester, Minn.

Doctor Spooner was certified by the American Board of Urology. He was a member of the North Central Urological Society, the American Urological Association, The Medical Society of Milwaukee County, the Milwaukee Urological Society, the Milwaukee Surgical Society, the American College of Surgeons, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Marcia; three sons, John, Alexander Dwight, Jr., and James; and two daughters, Marcia and Linda Mae.

Dr. John B. Wear, Madison, died May 12, 1964, at the age of 62.

He was graduated from the University of Texas Medical School in 1926 and interned at Vanderbelt Hospital in Tennesse. Doctor Wear served his residency at the University of Wisconsin where he had served on the staff as the clinical professor of surgery since 1928.

He was a commander in the United States Navy during World War II. Doctor Wear was head of the Urological Department at the U. S. Navy Hospital, San Diego, Calif., before assignment to the U.S.S. Sanctuary as assistant chief of surgery and chief urologist. He was among the first to see the A-Bomb havoc in Nagasaki.

Doctor Wear was certified by the American Board of Urology. He was a member of the American Urological Society, The American Association of Surgeons, the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Laurie; a son, Dr. John, Jr., and two daughters, Constance, and Mrs. Byron Ostby.

Dr. Frank W. Van Kirk, 89, retired Janesville physician, died May 24, 1964.

A native of Janesville, Doctor Van Kirk was graduated from Rush Medical College in 1901. After serving his internship at St. Luke's Hospital, Doctor Van Kirk practiced in Chicago until he returned to Janesville in 1909.

He was a fellow in the American Academy of Surgeons, a past president of the Rock County Medical Society, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Dr. Raymond M. Stark, Milwaukee, died May 25, 1964, at the age of 66.

A native of Watertown, Doctor Stark was a 1921 graduate of the University of Michigan School of Medicine, Ann Arbor, and interned at Milwaukee Hospital. He practiced in Appleton before coming to Milwaukee.

Doctor Stark retired from his position as medical examiner with International Harvester in 1963. He was medical examiner for the Milwaukee Railroad, a member of the American Association of Railway Surgeons, The Milwaukee County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Norma, and a daughter, Mrs. Robert A. Lines, St. Clair Shores, Mich.

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1964 **Wisconsin**

Sept. 19–Jan. 1: Wisconsin Medical Center Department of Surgery, Grand Rounds, Auditorium, Service Memorial Institutes building, Room 227, University of Wisconsin, Madison.

Oct. 1: Marquette–Jackson Clinic postgraduate program, Park Motor Inn, Madison.

Oct. 7–9: Wisconsin Nurses Association convention, Hotel Schroeder, Milwaukee.

Oct. 8, 15, 22, 29: Postgraduate courses in "Everyday Problems of Clinical Neurology," given by Marquette University School of Medicine in cooperation with Milwaukee County General Hospital, King Conference Room, Milwaukee County General Hospital, 8700 W. Wisconsin Avenue, Milwaukee.

Oct. 9: State Medical Society Council meeting, SMS headquarters, Madison.

Oct. 10–11: State Medical Society House of Delegates Fall Session, SMS headquarters, Madison.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

Oct. 15–17: District VI, American College of Obstetricians and Gynecologists, fifth annual conference on obstetric, gynecologic, and neonatal nursing, Coach House Motor Inn, Milwaukee.

Oct. 19–23: American College of Physicians Postgraduate Course No. 4, University of Wisconsin Medical Center, Madison.

Oct. 23–25: Wisconsin Association of Medical Technologists, fall convention, Hilton Inn, Milwaukee.

Oct. 29: U. W. "In Depth" program—Dermatology and Allergy: "Eczemas and Related Diseases"—at University Hospitals and State Medical Society, Madison.

Nov. 11–12: Fourth annual Milwaukee Medical Conference, Milwaukee County Hospital, Milwaukee.

Nov. 14: Wisconsin Society of Pathologists, annual fall meeting, Marquette University School of Medicine, Milwaukee.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

Dec. 9: U. W. "In Depth" program—Pediatrics: "The Management of Common Childhood Anemias"—at University Hospitals and State Medical Society, Madison.

1965

Jan. 23–24: Triological Society, Wisconsin Center, Madison.

Jan. 28: U. W. "In Depth" program—Surgery: "Colon and Rectal Surgery in Children and Adults"—at University Hospitals and State Medical Society, Madison.

Feb. 17: U. W. "In Depth" program—Orthopedics: "Congenital Hips and Foot Deformities in Children" —at University Hospitals and State Medical Society, Madison.

Mar. 18: U. W. "In Depth" program—Obstetrics and Gynecology: "Endocrine Problems in Gynecology"—at University Hospitals and State Medical Society, Madison.

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

1964 **Out-of-State**

Oct. 2–4: Course—University of Chicago Hospitals School of Inhalation Therapy, Center for Continuing Education, Chicago.

Oct. 5–7: University of Colorado School of Medicine, postgraduate course in fractures and dislocations, University of Colorado Medical Center, Denver.

Oct. 5–9: American College of Surgeons, annual clinical congress, Chicago, Ill.

Oct. 5–9: Sixteenth postgraduate assembly of The Endocrine Society, Mayo Clinic, Rochester, Minn.

Oct. 8–9: 16th Annual Conference on the Kidney, sponsored by the National Kidney Disease Foundation, New York Academy of Medicine, New York City.

Oct. 1964–Mar. 1965: Biweekly courses in Continuing Education Program in Psychiatry and Psychotherapy, Mount Sinai Hospital, Chicago, Ill.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Oct. 8–10: American College of Physicians annual fall meeting, Los Angeles, Calif.

Oct. 8–10: Association of American Physicians and Surgeons, 21st annual meeting, Roosevelt Hotel, New Orleans, La.

Oct. 10–14: American Society of Anesthesiologists, annual meeting, Americana Hotel, Bal Harbour, Fla.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Oct. 12–15: University of Cincinnati, symposium in occupational skin problems for physicians, Kettering Laboratory, Cincinnati, Ohio.

Oct. 13–18: 8th annual convention, American Association of Medical Assistants, Sheraton–Oklahoma Hotel, Oklahoma City.

Oct. 15–22: Third Annual Conference on Research in Medical Education in conjunction with the 75th Annual Meetings of the Association of American Medical Colleges, Denver, Colo.

Oct. 16–17: Midwestern Regional Physical Fitness Clinic for eight Midwestern states, sponsored by the President's Council of Physical Fitness and co-sponsored by the State Medical Society of Wisconsin, University of Illinois, Champaign–Urbana.

Oct. 19–21: American College of Gastroenterology, 29th annual convention, The Roosevelt, New York City.

Oct. 20–22: 71st annual meeting, Association of Military Surgeons of the United States, Sheraton–Park Hotel, Washington, D. C.

Oct. 21–22: 18th annual meeting of Council on Arteriosclerosis, American Heart Association, Hotel Shelburne, Atlantic City, N. J.

Oct. 21–23: American Society of Anesthesiologists, international symposium on pain, Henry Ford Hospital, Detroit.

Oct. 22–24: American College of Gastroenterology annual course in postgraduate gastroenterology, The Roosevelt, New York City.

Oct. 22–24: Postgraduate course in "Modern Concepts of Nutrition and Heart Disease," Mound Park Hospital auditorium, St. Petersburg, Fla.

Oct. 23–25: American Heart Association 37th annual scientific sessions, Convention Hall, Atlantic City, N. J.

Oct. 25: American College of Nutrition annual scientific meeting, New York City.

Oct. 26–29: National Safety Congress, Chicago.

Oct. 26–30: American College of Chest Physicians, postgraduate course in clinical cardiopulmonary physiology, Continental Hotel, Chicago.

Oct. 29–31: American College of Obstetricians and Gynecologists, 8th annual meeting of District VI, Marlborough Hotel, Winnipeg, Manitoba, Canada.

Oct. 29–31: First National Congress on Strokes, Palmer House, Chicago.

Nov. 3–7: American Society of Oral Surgeons, 46th annual meeting, Las Vegas, Nev.

Nov. 7–8: National conference on disaster medical care, Chicago.

Nov. 9–12: Interstate Postgraduate Medical Assembly, Pittsburgh, Pa.

Nov. 9–13: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, International Inn, Washington, D. C.

Nov. 13–16: 1964 annual convention of National Society for Crippled Children and Adults, Statler–Hilton Hotel, Detroit, Mich.

Nov. 15: First national careers conference for youth, Cobo Hall, Civic Center, Detroit.

Nov. 16–20: American College of Chest Physicians, postgraduate course No. 5, fundamental concepts of gastroenterology, University of Michigan Medical Center, Ann Arbor, Mich.

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2. 'Deprol' relaxes physical tensions, restores normal sleep and revives interest in food.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is compatible with drugs used to treat co-existing organic conditions.
5. 'Deprol' is relatively nontoxic and free of side effects.

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Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

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Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.
Nov. 16–18: Section on Otolaryngology of the Southern Medical Association annual meeting, Memphis, Tenn.
Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.
Nov. 16–20: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, Barbizon Plaza Hotel, New York City.
Nov. 28–29: First national conference on areawide health facilities planning, sponsored by AMA Council on Medical Service, Americana Hotel, Bal Harbour, Fla.
Nov. 29: Sixth National Conference on the Medical Aspects of Sports, Miami Beach, Fla.,
Nov. 29–Dec. 2: American Medical Association, 18th clinical convention, Auditorium and Exposition Hall, Miami Beach, Fla.
Dec. 14–16: Postgraduate Assembly in Anesthesiology, New York State Society of Anesthesiologists, Hilton Hotel, New York City.

1965

Jan. 25–30: Workshop in Teratology, University of California, Berkeley.
March 15–20: University of Colorado School of Medicine, 6th postgraduate course in medical technology.
May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.
July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.
Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.
Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.
Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

ACP Course Set for October in Madison

The American College of Physicians Postgraduate Course No. 4, "The Medicine of Tomorrow, Recent Advances of Immediate Clinical Interest in Molecular Biology and Other Basic Sciences," will be given at the University of Wisconsin Medical Center, Madison, Oct. 19–23. Co-directors are Drs. Karver L. Puestow, Ovid O. Meyer, and John LeRoy Sims.

Basic concepts which are on the verge of clinical application or are just being introduced into clinical medicine will be interpreted for the internist. Advantage will be taken of the unusual strength in fundamental biologic sciences at the university, drawing heavily for faculty on the Department of Medical Genetics, McArdle Memorial Laboratory for Cancer Research, Institute of Enzyme Research, and the laboratories and clinical facilities of the medical school.

Among the subjects considered will be emerging clinical applications of virology and electron microscopy, the relationships of immunology and pulmonary physiology to newly recognized patterns of lung disease, application of automation to laboratory techniques, and the burgeoning knowledge of tumor growth and therapy as related to fundamental cellular chemistry.

Additional opportunities will include presentation and demonstration of the gastric camera.

Military Surgeons To Meet

Modern man's changing living environment—from capsules on the bottom of the sea to capsules floating in space—will draw the attention of the nation's top scientific and medical personnel during the 71st annual meeting of the Association of Military Surgeons of the United States Oct. 20–22 at the Sheraton–Park Hotel in Washington, D. C. Registration for the meeting, theme of which will be "Military Progress through Scientific Achievement," begins Oct. 19. General chairman is Brig. Gen. Joe M. Blumberg, MC, USA, director of the Armed Forces Institute of Pathology in Washington.

Nutrition and Heart Disease

The Mound Park Hospital Foundation and the American Medical Association, with the joint sponsorship of the Department of Medical Education of the Mound Park Hospital and the American Academy of General Practice, and the cooperation of the Medical and Research Divisions of Bay Pines Veterans Administration Center and the Pinellas County Medical Society, announces a postgraduate course in "Modern Concepts of Nutrition and Heart Disease," Oct. 22–24 in the auditorium of Mound Park Hospital, St. Petersburg, Fla.

Eighteen credit hours in Category I will be allowed by the American Academy of General Practice. The fee is $15.00. Inquiries should be addressed to NUTRITION, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

Medical Center Grand Rounds

The Grand Rounds schedule for the Department of Surgery, Wisconsin Medical Center, has been announced by the department's chairman, Dr. Robert C. Hickey. The department would be pleased to have in attendance doctors from the Madison area or the state, Doctor Hickey states.

The Grand Rounds opened with plastic surgery on September 19 and general surgery September 26, and will continue as follows in the Auditorium, Service Memorial Institutes building, Room 227:

Oct. 3, General Surgery (6W)—Gastric Surgery; Oct. 10, General and Otolaryngology—Management of Head and Neck Cancers—William MacComb, M.D., guest professor; Oct. 17, Clinical Oncology—Selected Problems in the Surgery and Chemotherapy of Solid Tumors; Oct. 24, General Surgery (6E)—Biliary Surgery; Oct. 31, Alumni Day.

Nov. 7, Veterans Administration Hospital Surgical Services—Problems in Arterial-Peripheral Vascular Diseases; Nov. 14, Orthopedics—Upper Extremity Fractures; Nov. 21, Ophthalmology—Selected Patients for Presentations; Nov. 28, Resi-

dents, General and Thoracic—Problem Patients for Discussion.

Dec. 5, Cardiovascular and General—Thromboembolic Disease; Dec. 12, Urology—Selected Patients for Presentation; Dec. 19, Residents, General and Thoracic—Problem Patients for Discussion.

ACOG Nursing Conference

The American College of Obstetricians and Gynecologists' fifth annual conference on obstetric, gynecologic, and neonatal nursing will be held Oct. 15–17 at the Coach House Motor Inn, Milwaukee.

The conference is designed to provide opportunity for nurses to hear about and discuss current problems and advances in nursing care, and to acquaint them with new trends in medical and surgical therapy. A wide selection of pertinent topics will be presented by a group of nationally prominent nurses and physicians, among them Miss Helen Callon of Madison, who will share with the chairman of District VI, American College of Obstetricians and Gynecologists, the introduction and welcome to the conference; Dr. Frederick J. Hofmeister of Milwaukee, who will speak on "A Concept of Gynecologic and Obstetric Care;" Mrs. Barbara Brown of Wauwatosa, whose topic will be "A Concept of Obstetric and Gynecologic Care;" and Dr. C. Raymond Headlee, Milwaukee, Continuing Seminar on Human Reproduction: Psychiatric Conflicts of Pregnancy.

Program chairman is Dr. Richard F. Mattingly, Milwaukee.

Regional Physical Fitness Clinic

The University of Illinois at Champaign–Urbana will be the setting on Oct. 16–17 for the Midwestern Regional Physical Fitness Clinic for the States of Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Missouri, and Wisconsin. The State Medical Society of Wisconsin is co-sponsoring the clinic, whose purpose is to interpret the recommendations of the Council for home, school, and community programs, to provide information on effective ways to increase fitness among youth and adults, and to stimulate physical fitness activities at state, district, and local levels. The clinic is open to everyone and will feature demonstrations illustrating various techniques for improving physical fitness. Additional information may be obtained by writing to Norman Johnson, Director, Conferences and Institutes, University of Illinois, 116 Illini Hall, Champaign, Ill. 61822.

Gastroenterological Convention

The 29th annual convention of the American College of Gastroenterology will be held Oct. 19–21 at The Roosevelt, New York City. Copies of the program and further information may be obtained in writing to: American College of Gastroenterology, 33 West 60th St., New York, N. Y. 10023.

Immediately following the convention, on Oct. 22–24, the annual course in postgraduate gastroenterology will again be given, at The Roosevelt and at Mt. Sinai Hospital, with attendance limited to those who have registered in advance.

Clinical Neurology Course

Marquette University School of Medicine in cooperation with Milwaukee County General Hospital announces a postgraduate course in "Everyday Problems of Clinical Neurology" on four Thursday evenings, Oct. 8, 15, 22, and 29, in King Conference Room, Milwaukee County General Hospital, 8700 W. Wisconsin Avenue, Milwaukee.

Director of the course will be Dr. Warren H. Kempinsky, professor and chairman, Department of Neurology, Marquette University School of Medicine, and director of neurology at Milwaukee County General Hospital.

The American Academy of General Practice offers Category I credit of eight hours. Tuition will be $25.00 but there is no charge for residents, interns, or medical students.

Reservations should be made with Joseph W. Rastetter, M.D., Director Postgraduate Medical Education Programs, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226.

State Nurses Meeting in Milwaukee

"Nursing: Concerns—Challenges—Changes" will be the theme of the convention of the Wisconsin Nurses Association Oct. 7–9 at the Hotel Schroeder, Milwaukee.

Speakers will include Greta I. Fraser, R.N., director of continuing education, College of Nursing, University of Kentucky, Lexington; Daisy M. Tagliacozzo, Ph.D., acting chairman of the Department of Political and Social Science, Illinois Institute of Technology, Chicago; Dr. Darold Treffert, acting superintendent, Winnebago State Hospital, Winnebago; and Dr. Addis C. Costello, internist and clinical instructor at Marquette University School of Medicine.

Also scheduled are a symposium, six nursing clinics, film previews, and a presentation highlighting the work of the Wisconsin State Board of Nursing, Madison. M. Annie Leitch, R.N., director of programs for state boards of nursing of the ANA, will begin the discussion.

Betty M. Callow, R.N., WNA president, Wausau, will preside over the business sessions. President-elect is Mrs. Elizabeth Regan, R.N., associate professor of nursing at the University of Wisconsin extension division, Milwaukee.

Endocrine Society

The 16th postgraduate assembly of the Endocrine Society will be held Oct. 5–9 at the Mayo Clinic, Rochester, Minn., as part of the centennial celebration of the Mayo Clinic-Mayo Foundation. General chairman is Dr. J. C. Beck, Royal Victoria Hospital, Montreal, Canada. Local chairman is Dr. Edward H. Rynearson, Mayo Clinic, Rochester, Minn. 55901.

from pian in Ubangi to tonsillitis in Maine

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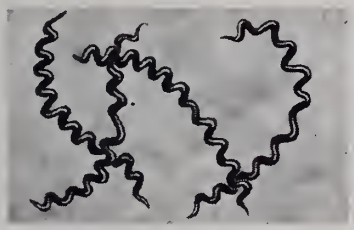
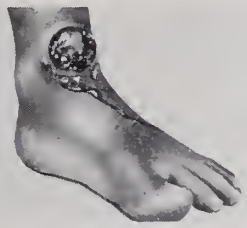
Pian is a disease that is contagious in the tropics but apparently never infectious in other areas. Caused by *Treponema pertenue,** it is often acquired during childhood and is widespread among native tribes such as the Babinga, a race of forest pigmies in Ubangi. The organism enters the body through cuts or abrasions of the skin, usually by direct contact, but flies, especially species of *Hippelates,** can also transmit the disease. Within three to four weeks a granulomatous lesion (the "mother pian"*) develops at the site of inoculation. Six to twelve weeks later a generalized eruption occurs. After several years, tissue-destructive tertiary lesions of the skin and bones may be seen. Disfiguring and disabling, these lesions are both a social and economic handicap to many adult patients. Diagnosis rests on appearance of lesions, history of contact, and identification of the spirochete on dark-field examination or by Giemsa-stained smear. A positive reaction to serologic tests for syphilis is also obtained, although pian is not a venereal disease. **illustrated*





SIDE EFFECTS: Glossitis and allergic reactions have been reported as rare side effects. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

PRECAUTIONS: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated.

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AMA Clinical Convention

The 18th clinical convention of the American Medical Association will be held Nov. 29-Dec. 2 in the Auditorium and Exposition Hall in Miami Beach, Fla. It will include a breakfast roundtable discussion, scientific sessions, a three-session course in obstetrics for the general practitioner, closed circuit television, motion picture premieres, and 275 scientific and industrial exhibits.

Immediately preceding the convention, on Nov. 28–29, the first national conference on areawide health facilities planning will be held in Bal Harbour, Fla. Sponsored by AMA's Council on Medical Service, the meeting will be at the Americana Hotel.

In conjunction with the AMA clinical convention, the sixth national conference on the medical aspects of sports will be held Nov. 29 at the Deauville Hotel in Miami Beach. Included will be papers, panels, and discussions relating to training and conditioning, prevention and treatment of injuries, physiology of sports participation, and other subjects.

Milwaukee Medical Conference

Medical and surgical aspects of trauma will be considered at the fourth annual Milwaukee medical conference Nov. 11–12 in Milwaukee. The scientific program will be held in Coffey Auditorium of Milwaukee County Hospital Nov. 11 from 12:30 p.m. to 5 p.m. and Nov. 12 from 9 a.m. to 3:30 p.m. Preceding the Nov. 11 session, a program devoted to the management of specific injuries will be presented by members of the Milwaukee County Intern-Resident Association, a co-sponsor of the conference. Members of that association will hold their annual banquet at 8 p.m. Nov. 11 following a reception at 6:30 p.m. at the Coach House Motor Inn, where paid participants in the conference are invited to meet the faculty.

Section VI (Wisconsin, Indiana, Illinois, and Iowa) of the American College of Surgeons Committee on Trauma, a co-sponsor of the program, will meet at noon Nov. 12 at Milwaukee County Hospital.

Conference registration fee is $5.00. There is no fee for students, interns, or residents. Inquiries may be addressed to: L. W. Worman, M.D., Chairman, 1964 Milwaukee Medical Conference Planning Committee, The Medical Society of Milwaukee County, 756 N. Milwaukee St., Milwaukee, Wis. 53202.

16th Annual Conference on the Kidney

The 16th annual conference on the kidney will be held at the New York Academy of Medicine, New York City, Oct. 8–9. Sponsored by the National Kidney Disease Foundation, the conference will review in depth the background and present status of transplantation of the kidney (and other organs) in man. For the first time, attendance will be open to all physicians and surgeons having particular interest in the renal field.

Careers Conference for Youth

The first national careers conference for youth, designed to help relieve the critical shortage of professional rehabilitation personnel by interesting high school and college students in the rehabilitation professions as their life work, will highlight the annual convention of the National Society for Crippled Children and Adults (The Easter Seal Society) Nov. 15 at Cobo Hall in Detroit's Civic Center.

Other sessions of the convention, which opens Nov. 13 and continues to Nov. 16, will be held at the Statler–Hilton Hotel in Detroit.

SMA Ophthalmology, Otolaryngology Sections

The Section of Ophthalmology of the Southern Medical Association has completed an outstanding program for its annual meeting in Memphis, Tenn., Nov. 16–19. The sessions will include live television of cataract and muscle surgery, and scientific papers on a variety of subjects. Further information may be obtained by contacting the Secretary of the Section of Ophthalmology, Dr. George S. Ellis, 812 Maison Blanche Bldg., New Orleans 16, La.

A closed circuit TV program and a "Memphis Day" program are planned for the 58th annual meeting of the Section on Otolaryngology of the SMA Nov. 16–19 at Memphis.

First National Congress on Strokes

The First National Congress on Strokes, designed to stimulate a wide-spectrum program of prevention and management of strokes and rehabilitation of stroke patients, has been scheduled for Oct. 29–31 at the Palmer House, Chicago. Sponsoring agencies are the American Medical Association, American Heart Association, Heart Disease Control Program of the U. S. Public Health Service, and Vocational Rehabilitation Administration of the Department of Health, Education and Welfare.

Wisconsin Medical Technologists

Several Wisconsin physicians will be participating in the fall convention of the Wisconsin Association of Medical Technologists. The convention will be held on October 23, 24, and 25, at the Hilton Inn, Milwaukee.

On Friday, October 23, an immunhematology workshop on Hemolytic Disease of the Newborn will be conducted by Dr. Gerald McKay. Dr. R. Scheidt will lead a session in chemistry, Advances in Clinical Chemistry.

Highlighting Saturday's program will be Abnormal Hemoglobins by Dr. E. C. Rossi; The Medi-

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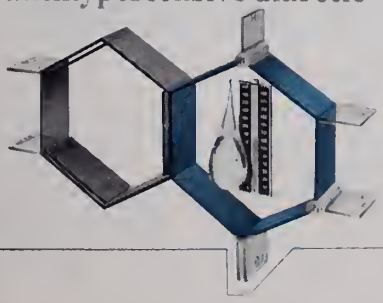

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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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cal Technologist and Radioisotopes by Dr. G. Mead; The Role of an Enzyme, Neuraminidase, in Infectious Disease by Dr. R. Kelly; Clinical Measurement of Acid-base Balance by Dr. E. Lenon; PKU Detection Program by Dr. P. E. Podruch; and A Clinical and Laboratory Outlook of Dramamine in Labor by Dr. J. Massert.

Dr. John Hurley, Milwaukee, will be the banquet speaker Saturday evening. The meeting will conclude on Sunday following two papers and a business meeting.

Workshop in Teratology

A Workshop in Teratology will be held at the University of California, Berkeley, on Jan. 25–30, 1965. It is sponsored jointly by the Drug Research Board of the National Academy of Sciences—National Research Council, the Teratology Society and the University of California, under a grant from the Pharmaceutical Manufacturers Association. Its planning is an outgrowth of the first such conference, held recently at the University of Florida under the auspices of the Commission on Drug Safety. Fundamental considerations in research on problems of congenital disorders will be presented in a series of lecture and laboratory sessions. Details of the program and applications for participation may be obtained by writing to Dr. C. W. Asling, Workshop in Teratology, Department of Anatomy, University of California, Berkeley, Calif. 94720.

Marquette–Jackson Clinic PG Program

The thirty-fourth annual Marquette–Jackson Clinic postgraduate meeting will be held Thursday, Oct. 1, at the Park Motor Inn in Madison. Speakers from the Jackson Clinic include Drs. W. J. McAweeney and D. W. Hurst of the Department of Medicine; Dr. Barbara A. Brew, Obstetrics & Gynecology; Dr. O. F. Foseid, Department of Surgery. Speakers from Marquette University have not been announced.

American College of Physicians

Course No. 5 of the ACP postgraduate program will be held November 16–20 at the University of Michigan Medical Center, Ann Arbor, Mich., and will feature the Fundamental Concepts of Gastroenterology. Purpose of the course will be to cover the various diseases affecting the gastrointestinal tract and to incorporate recent concepts of immunology, genetics, electron microscopy, etc., in addition to indicating the biochemical and physiological features.

Panels will be utilized freely, so that methods of treatment can be included and adequate time will be allotted to question-and-answer periods.

Dr. H. M. Pollard is the director of the course. Minimal registration is 60; maximal registration, 120.

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Journal
Established 1903
Annual Subscription $6.00
Single Copy 1.00
Previous Years' 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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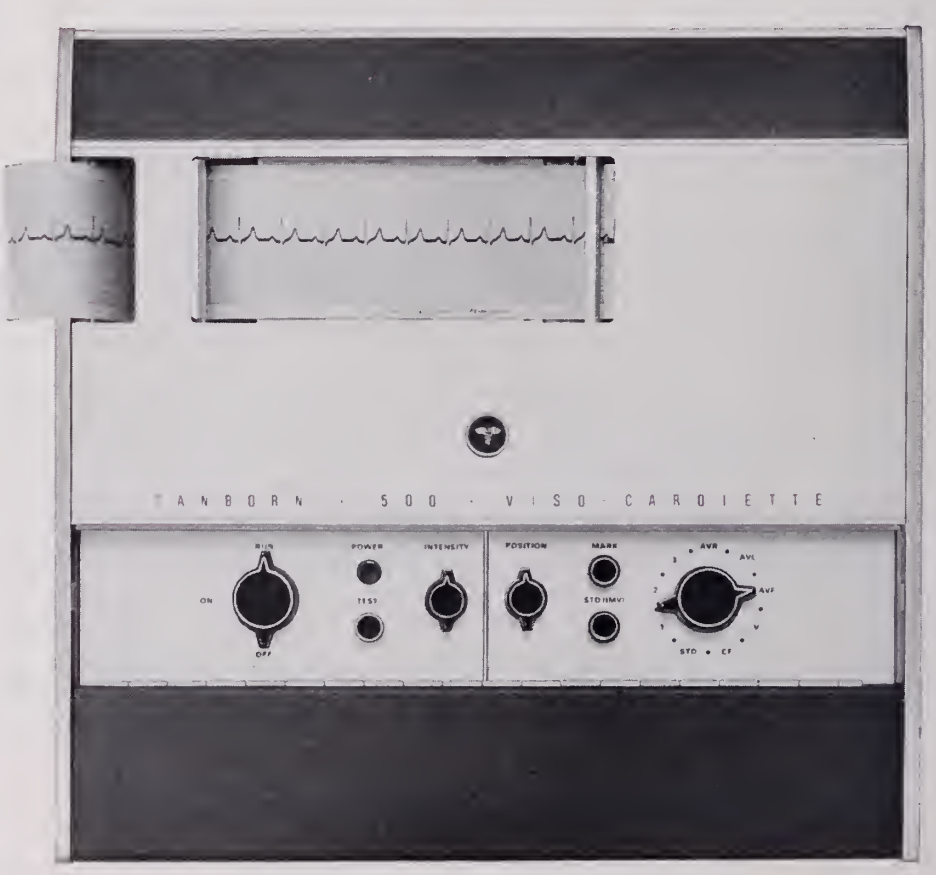

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CLINICAL CENTER STUDY OF EWING'S SARCOMA

To SMS:

The cooperation of physicians is requested in a continuing study of Ewing's sarcoma by the Radiation Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Md.

Referrals of patients with a radiographic diagnosis of Ewing's sarcoma are needed. It is desired that such patients be referred prior to establishment of the diagnosis by biopsy in order that they may be admitted for biopsy and immediate institution of therapy.

Physicians interested in having their patients considered for the study may write or telephone:

DR. RALPH E. JOHNSON
Clinical Center, Room 6–B–09
National Institutes of Health
Bethesda, Maryland 20014
Telephone: 656–4000, ext. 65147
(area code 301)

GRATITUDE EXPRESSED

To DOCTOR GOLDSTEIN:

The Wisconsin State Medical Assistants Society wishes to express their gratefulness to you for the heartening words of praise displayed in your editorial, "True Friends," which appeared in the July issue of the *Wisconsin Medical Journal.*

It is most gratifying to pick up the *Wisconsin Medical Journal* and find that space has been allotted to our Society and its activities. Your most encouraging words are especially welcome at this time when our Membership Extension Committee is scheduling a series of preorganizational meetings. We feel confident that, through your expression of evaluation of The Wisconsin State Medical Assistants Society, we will encounter no difficulty in organizing additional component chapters of Medical Assistants.

Again, our sincerest thanks to you, Doctor Goldstein, for all the courtesies extended to our organization.

MISS ALICE L. ROELSE
Public Relations Chairman
Wisconsin State Medical
Assistants Society

ACIR APPRECIATIVE

To SMS:

The third annual Medical Tribune Auto Safety Award for "lifesaving achievement in the service of health" was recently conferred upon the ACIR [Automotive Crash Injury Research] project as the organizational winner.

In accepting this coveted award my associates and I are reminded of the recognition and merit due all those individuals who have made possible the interstate ACIR program.

LETTERS

I refer of course not only to our predecessors, the more than 10,000 dedicated state police and highway patrol officers but also to the thousands of physicians in the 28 states in which ACIR programs have been undertaken.

It is axiomatic that without the voluntary efforts of police accident investigators and physicians to produce reliable factual accident-injury data, ACIR's contribution to progress in the development of improved automotive passenger protection would not be possible.

It is therefore with a deep sense of appreciation that we at ACIR salute the members of the State Medical Society of Wisconsin who, as a supplement to efforts directed toward accident prevention on our highways, have made an important contribution toward the injury prevention approach in this vital area of traffic safety. Please convey to your membership and your staff our expression of gratitude.

ROBERT A. WOLF
Director, Automotive Crash
Injury Research
Cornell University
Buffalo, N. Y.

WISCONSIN SURGEON REPORTS ON VIENNA SURGICAL CONGRESS

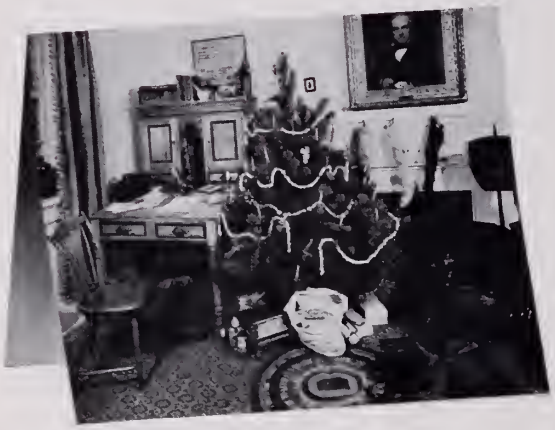
To WMJ:

The meeting of the International College of Surgeons, held in Vienna in 1964, was a remarkable success. It was attended by about 2,000 surgeons from all parts of the world, 415 of them from the United States.

Vienna is a beautiful city with a population of 1,500,000. It is a city of flowers and parks. It is a city of song where the people are friendly. The opera presented daily is wonderful and the theater is always sold out. Prices in Vienna have increased as they have all over the world. Hotel rooms and clothing are about the same in price as in the United States, but food is less expensive.

The surgical program covered practically all of the problems in surgery in addition to new research. One of the lectures which appealed to me was given by Dr. Peter Rosi of Chicago. He gave a very detailed report on his results in gastric surgery, especially the recurrence rate of ulcer in gastric resection for ulcer. He stated that in his surgical experience high gastric resection, or vagotomy with a 50% gastric resection, gave about the same rate of recurrent ulcer. He also stated that diarrhea was one of the principal complications of vagotomy. Doctor Rosi feels that selective vagotomy (if possible), not including the branches to the liver and pancreas, etc., with a subtotal gastrectomy (50%), would probably give the best results.

A Unique Christmas Card



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Dr. Ralph Coffey of Kansas City gave an interesting lecture on the ligament of Treitz. We all know it's there, but perhaps we are not all aware that at times it causes kinking of the jejunum. In his lecture Doctor Coffey stated he resects part of the ligament to avoid this kinking and possible obstruction. The title of his paper was "An Anatomic Variant of the Ligament of Treitz as a Cause of the Afferent Loop Syndrome in Billroth II Resection."

Dr. C. J. Hunt of Kansas City presented a lecture on acute colon obstruction. He discussed the merits of open colostomy and colon colostomy.

Some well known foreign surgeons gave noteworthy lectures. Dr. Kamei Nakayama, Chiba, Japan, lectured on transplantation of a freely resected segment of the colon to the cervical defect for carcinoma of the esophagus. He reported 20 cases. Doctor Nakayama also reported on liver lobe and pancreatic resection for carcinoma of the stomach. Doctor Nakayama is president of the International College of Surgeons this year. It has been my privilege to see surgery performed by this Japanese surgeon. He is truly a master surgeon. He operates a 750-bed hospital in Chiba (a suburb of Tokyo) where the patients' relatives supply the food and bed clothes. I asked Doctor Nakayama why cancer of the stomach was more prevalent in Japan than in any country in the world. He said that he did not know, but he thought heredity, a high rice and raw fish diet, and hot sake wine were all factors.

Dr. Pan Chrysopathis of Athens, probably one of the best surgeons in Greece, who trained under Dr. Kamei Nakayama for two years, gave an interesting talk and demonstration. He discussed the free auto transplantation of a graft of the sigmoid colon for the replacement of the diseased cervical esophagus (cancer of the larynx infiltrated into the cervical esophagus). It has been my good fortune to observe the surgery of Doctor Chrysopathis in Athens and he is certainly one of the world's most accomplished surgeons.

It seems to me these meetings in foreign lands are of value in that one observes the surgical technique of some of the world's best surgeons and learns their answers to the problems of present day surgery.

VERNON J. HITTNER, M.D.
126 South Main Street
Seymour, Wisconsin

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin, 53701.*

ASHLAND–BAYFIELD–IRON

Dentists, attorneys, and pharmacists were among the group of 40 attending the September meeting of the Ashland–Bayfield–Iron County Medical Society.

At the dinner meeting at the Scottie Club, Mrs. C. A. Grand of Ashland acted as mistress of ceremonies and Mrs. John J. Satory of LaCrosse addressed the group. Mrs. Satory is president of the Woman's Auxiliary to the State Medical Society. Mrs. F. H. Wolf, president-elect, of La Crosse, was also present.

BARRON–WASHBURN–SAWYER–BURNETT

A congenital and rheumatic heart disease clinic was held September 9 at the Hayward Area Memorial Hospital in Hayward under the sponsorship of the Wisconsin Heart Association and the Barron–Washburn–Sawyer–Burnett County Medical Society.

BROWN

The widest mass immunization program ever held in the Green Bay area got underway September 19 when more than 82,000 Brown County residents thronged to seven feeding stations to receive the Sabin oral vaccine in a two-stage feeding program co-sponsored by the Brown County Medical Society and the Green Bay Junior Chamber of Commerce.

Dr. Richard L. Myers, Green Bay, general chairman of the project, termed it the "most outstanding medical event to occur in Brown County." Plans for the all-inclusive feeding program, which will be concluded November 7, were announced late in the summer by *Dr. Lyle H. Edelblute*, Green Bay, medical society president.

Photo courtesy of GREEN BAY PRESS–GAZETTE

Directing the two-stage Sabin oral vaccine feeding program in the Green Bay area are, from left to right above, James Van Egeren of the Green Bay Junior Chamber of Commerce; *Dr. Richard L. Myers*, general chairman; *Dr. Lyle H. Edelblute*, president of the Brown County Medical Society; and Farrest Clothier of the Brown County Pharmaceutical Association. The Brown County Medical Society and the Green Bay Jaycees are co-sponsors of the program, which got underway September 19. The second and final feeding is scheduled for Saturday, November 7.

Physicians whose names appear in italics are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS

DANE

Seventy member physicians vied for top honors on the golf course at the annual Dane County Medical Society Golf Tournament September 22 at Nakoma Country Club, Madison. Winners were *Drs. Phillip Schoenbeck*, Stoughton, low gross; Kenneth Loken, Middleton, low net prize; *J. N. Moore*, Madison, low net trophy; *Donald Schuster*, Madison, longest drive; *Russell P. Sinaiko* and J. H. Brandenburg, Madison, closest to the pin.

More than 90 members attended the dinner and evening's festivities. *Dr. William S. Middleton*, former dean of the University of Wisconsin Medical School and former Chief Medical Director of Veterans Affairs, who is now back in Madison, was present for the occasion.

New members of the Society are *Drs. LeRoy A. Ecklund, Rudolf W. Link, William M. Buzogany, Richard A. Graf, Frederick M. Rich, Paul O. Simenstad, William A. Kisken, Arthur A. Siebens, Bernhardt E. Stein, Andrew B. Crummy, Robert A. Sievert*, and *John R. Allen*.

Three of the group, Doctors Ecklund, Link and Buzogany, are now on the staff of Mendota State Hospital, Doctor Buzogany in the capacity of director of the Child-Adolescence Program. Engaged in private practice in Madison are Doctors Graf, Rich, and Simenstad. Serving at University Hospitals are Doctors Kisken, Stein, and Crummy, instructors, and Siebens, director of the Rehabilitation Center. Doctor Sievert is director of the Physical–Medical Rehabilitation Department at Madison General Hospital and Doctor Allen is employed with the Wisconsin State Department of Public Welfare. He is renewing his membership in the Dane society after having been a member in the past.

GRANT

The Grant County Medical Society in August donated $4,425.65 to the CES Foundation of the State Medical Society for loans to Grant county residents who are students of medicine, dentistry, pharmacy, and nursing. The money will be loaned equally in the four fields, and will be administered by the Foundation trustees in similar fashion as the Foundation's Student Loan Account. This money was received by the county society as a result of its recent polio immunization program.

KENOSHA

At its September meeting in the Elks Club, Kenosha, the Kenosha County Medical Society acknowledged the presentation of a plaque awarded to *Dr.*

Helen A. Zank Binnie by the State Medical Society for her 50 years of membership. She is now a life member of the state society. Doctor Binnie joined the Kenosha society in 1929.

A program on "Interprofessional Relationship," by John Robinson, was presented at the Society's regular monthly dinner meeting on October 1 at the Elks Club.

Members of the Kenosha County Medical Society in August donated $1,000 to the Student Loan Account of the CES Foundation of the State Medical Society in honor of Sally Crownhart Hegley who created a backdrop seal of the Kenosha society. It will be displayed by the Society at all its official gatherings. In accepting the backdrop seal, the Society gave unanimous and enthusiastic acclaim for the exquisite workmanship and overall striking beauty of the creation.

LAFAYETTE

The Lafayette County Medical Society in September donated $1,500.00 to the CES Foundation of the State Medical Society for use as needed following a plea by Foundation trustees for additional funds to meet the continuing expansion and development of Foundation affairs.

MARINETTE–FLORENCE

In July the physicians of Marinette county donated $3,189.00 to the CES Foundation of the State Medical Society. This amount was the surplus realized from the county's polio immunization program. It will be divided equally for loans to Marinette county residents who are students in medicine and nursing. Other terms of the loans are similar to those already established in the Foundation's Student Loan Account.

MENOMINEE

In July a $3,000 scholarship and loan fund for young people of Menominee County who are interested in health careers was established through the CES Foundation of the State Medical Society by a grant from the estate of the late Miss Ruth Coe of Madison. Miss Coe was instrumental in beginning the practical nurses program in the state and served as president of the State Nurses Association. *Dr. Addie M. Schwittay* of Madison handled the transaction for the estate, knowing that it was the wish of Miss Coe to establish such a fund.

POLK

As host for the September meeting of the Polk County Medical Society, *Dr. H. A. Dasler* of Amery arranged a program on athletic injuries for head athletic coaches and physicians of the area. Present for the meeting at Wayne's Cafe in Amery were Dr. Donald R. Lannin, team physician for both the University of Minnesota Gophers and Vikings professional football teams, and Fred Zanberletti, Vikings trainer.

The Polk county society donated $600 to the St. Paul mobile blood unit, according to an announcement made during the annual meeting of Polk County chapter of the American Red Cross.

RACINE

The Golden Lantern in Racine was the setting on Sept. 17 for the regular business meeting and dinner of the Racine County Medical Society. During the hour preceding the dinner, an open house was held at the Medical Clinic.

RICHLAND

Social security and disability were discussed at the meeting of the Richland County Medical Society in May, according to *Dr. L. M. Pippin*, president, Richland Center. *Dr. William P. Crowley, Jr.*, Madison, chief consultant for the state agency which makes disability determinations, was the principal speaker and a film called "The Disability Decision" was shown. Dinner at the Park Hotel preceded the program in the Richland Hospital library.

Dr. Leigh M. Roberts of University Hospitals, Madison, presented a paper on the subject, "Psychiatric Management of Depression," at the September meeting of the Richland County Medical Society in the library of the Richland Hospital.

TREMPEALEAU–JACKSON–BUFFALO

Galesville members were hosts for the August meeting of the Trempealeau–Jackson–Buffalo County Medical Society at Club Midway, Independence.

WINNEBAGO

Dr. George W. Arndt, Sr., Neenah, served as program chairman for the September dinner meeting of the Winnebago County Medical Society at the Valley Inn, Neenah. Speaker for the event was *Dr. Edward E. Houfek* of Sheboygan, whose topic was "Emotional Problems in General Hospitals."

WOOD

Although he has given up his private practice in Wisconsin Rapids and resigned from his partnership in the Garrison–Handy Clinic to enroll in the University of Minnesota Graduate School, *Dr. George Handy* is continuing as president of the Wood County Medical Society. He is seeking a master's degree in public health and began classes September 21 in Minneapolis.

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features the following new books in their full page advertisement appearing elsewhere in this issue:

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Medical Alumni Association

The Wisconsin Medical Association held its annual fall meeting October 31, Homecoming. *Dr. Sture A. M. Johnson,* professor of medicine, presented "Cutaneous Lesions as They Reflect Systemic Disease." *Dr. John F. Morrissey,* assistant professor of medicine, spoke on "Observations on the Use of the Gastrocamera." He was followed as speaker by *Dr. Herman W. Wirka,* professor of surgery. Program chairman was *Dr. Frank Weston,* president of the association.

Fond du Lac Medical Assistants Society

Plans for the annual auction to be held in November were made by members of the Fond du Lac County Medical Assistants Society when they met recently in the library of St. Agnes Hospital, Fond du Lac.

Dr. Jane H. Koll, member of the city heart council, and Paul Behling, field representative for the Wisconsin Heart Association, presented a program. A newly-released film, "Pulse of Life," was viewed after which members participated in mouth-to-mouth resuscitation and closed chest heart massage, using a manikin.

The short business meeting which followed was conducted by Miss Arline Rady, president-elect. Miss Rady is assuming the duties of Miss Lucille Cassidy, who has returned to school.

Wisconsin Heart Association

Dr. Robert S. Ascheim, heart disease control officer for the U. S. Public Health Service, discussed strokes when he addressed the Salvation Army Home League July 8. His appearance was sponsored by the Wisconsin Heart Association as part of its public education program.

Milwaukee Medical Assistants Society

Officers elected at the May meeting of the Milwaukee County Medical Assistants Society were installed by Miss Edith Murphy, immediate past president, Wisconsin State Medical Assistants Society, at the annual banquet June 18 in Milwaukee at the Schlitz Brown Bottle.

Officers installed were Miss Marvis Sitkoski, president; Miss Judith Kerl, president-elect; Mrs. Nyla Libke, treasurer; Mrs. Peggy Forrest, corresponding secretary; Miss Phyllis Schirmer, recording secretary.

Plans are being made for the annual convention of the Wisconsin State Medical Assistants Society which will be held at the Coach House Motor Inn, Milwaukee, in June of 1965.

Medical Record Librarians

The Western Wisconsin group of the American Association of Medical Record Librarians elected officers for 1964–1965 at a bimonthly meeting in August at St. Joseph's Hospital, Chippewa Falls. Mrs. Luella Penner, Hudson Memorial Hospital, Hudson, was chosen as president, and named to office with her were Sister Mario, St. Joseph's Hospital, Chippewa Falls, vice-president, and Mrs. Sybil Reiter, Luther Hospital, Eau Claire, secretary-treasurer.

Sister Mary Philomene, director of nursing services at St. Joseph's Hospital, initiated an educational discussion after presenting her topic on "Interdepartmental Communications and Relationships of the Medical Record Librarian to Nursing Service."

Wisconsin Heart Association, Wood Unit

Dr. Robert L. Johnson of Wisconsin Rapids, chairman of the Wood County unit of the Wisconsin Heart Association, accepted a plaque in behalf of the unit for developing the outstanding program of the year. It involved screening of heart sounds in 1,312 fifth graders in the county in an effort to discover signs of organic heart disease.

Of the 1,424 fifth grade students in Wood county, 1,312 obtained the necessary parental consent to take part. Each was examined by one of the 15 county physicians who donated a total of 74 hours of examining time to the program.

Waukesha Medical Assistants Society

At an installation banquet held at the Tyrolean Town House in West Allis, Mrs. Peggy Gallagher was installed as president of the Waukesha County Medical Assistants Society. Taking office with Mrs. Gallagher in a ceremony performed by the state president, Mrs. Aleen Piepenburg of Waukesha, were Mrs. Jan Staszewski, president-elect; Mrs. Margaret Russell, treasurer; Mrs. Ethel Erdman, recording secretary; and Mrs. Marion Walters, corresponding secretary.

State adviser of the group is *Dr. T. H. McDonell,* Waukesha. County advisers are *Drs. John L. Raschbacher,* Big Bend, and *Drs. Warren G. Smirl* and *Thomas E. Dugan,* Waukesha.

Wisconsin Society of Internal Medicine

Officers of the Wisconsin Society of Internal Medicine for 1963–1964 are *Dr. William L. Coffey, Jr.,* Milwaukee, president; *Dr. George E. Gutmann,* Janesville, president-elect; and *Dr. John H. Wishart,* Eau Claire, secretary-treasurer.

Delegates to the State Medical Society Section on Internal Medicine are Doctor Gutmann and *Dr. W. K. Simmons,* Rhinelander. Alternates are *Dr. L. J. Kurten,* Racine, and *Dr. R. L. Gilbert,* La Crosse.

Physicians whose names appear in italics are members of the State Medical Society.

American Cancer Society, Waukesha Area

Dr. John Hartwick of New Berlin is the new chairman of the Muskego–New Berlin branch of the American Cancer Society. The latter has seven branches in the Waukesha County area. An innovation this year is the choice of a physician to head each organization in the belief that a doctor has the greatest understanding of cancer patients and their needs.

Wisconsin State Board of Nursing

Miss Ione Rowley of Madison, who is director of the Bureau of Public Health Nursing, Wisconsin State Board of Health, was elected president at the annual meeting of the Wisconsin State Board of Nursing. Elected vice-president was Miss Frances Avery of Milwaukee, associate professor at Marquette University College of Nursing.

The Board reappointed Mrs. Florence Byrne of Superior to a three-year term on the Wisconsin Committee of Examiners for Trained Practical Nurses. Sister Mary Carmel of Manitowoc was appointed to a four-year term on the Wisconsin Committee of Examiners for Nurses.

Twenty-one registered nurses were awarded scholarships totaling $26,600 for advanced educational preparation.

Wisconsin Heart Association

Robert Grover of Kenosha was awarded a plaque honoring him for six years of service as a director of the Wisconsin Heart Association. The presentation was made by *Dr. William A. Mudge, Jr.*, Kenosha County chairman of the association, and Attorney Duane D. Shoufler of Kenosha, recently-named board member.

Central Association of OB-GYN

The 32nd annual meeting of the Central Association of Obstetricians and Gynecologists was held Sept. 24–26 at the Schroeder Hotel, Milwaukee.

Wisconsin physicians participating in the scientific sessions were *Dr. William Kiekhofer* of Madison and *Drs. Jack A. Klieger* and *John J. Massart* of Milwaukee. The two Milwaukee doctors presented a paper on "A Clinical and Laboratory Survey into the Oxytocic Effects of Dramamine in Labor."

Joint Meeting of O-O Groups

Maxwelton Braes, Bailey's Harbor, was the setting for a joint meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology and the Wisconsin Otolaryngological Society on Sept. 12 and 13.

Speakers at the Saturday sessions were Dr. Charles J. Pophal, resident at the Veterans Administration Center at Wood, "Unusual Case of Conduction Hearing Loss," with discussion by *Dr. W. B. Larkin* of Eau Claire and *Dr. Rollo Lange* of Madison; Dr. Marvin E. Collentine, also a resident at the Wood Veterans Administration Center, "Melanosarcoma of the Sinuses," with discussion by *Dr. Howard High* of Milwaukee; Dr. William H. Saunders, professor of otolaryngology at Ohio State University, who presented two papers, "Surgical Treatment of Certain Types of Epistaxis" and "Differential Diagnosis of Vertigo;" and Dr. Eugene R. Folk of Skokie, Ill., whose two papers were on the subject of "Indications for Recession of One Medial Rectus" and "Problems in Strabismus Surgery."

A business meeting was held Sunday, following breakfast.

Dr. Hamlin New WAGP President

Dr. W. D. Hamlin, Mineral Point, succeeded *Dr. Walton R. Manz*, Eau Claire, as president of the Wisconsin Academy of General Practice at that organization's 16th annual meeting September 20 through 22 in Milwaukee. Named president-elect was *Dr. Howard M. Klopf*, Milwaukee.

Reelected were *Dr. Thomas J. Cox*, Milwaukee, secretary-treasurer; *Dr. Marvin H. Olson*, Schofield, speaker; and *Dr. Gerald J. Derus*, Madison, vice-speaker. *Dr. George V. Murphy*, South Milwaukee, was elected to the board of directors, and *Drs. Emmet R. Killeen*, Green Bay, and *John G. Jamieson*, Racine, were reelected to the board.

Specialty Societies Contribute

Several Wisconsin specialty groups have contributed to the CES Foundation of the State Medical Society during 1964. A total of $608.00 has been received from the Wisconsin Society of Anesthesiologists, Wisconsin Radiological Society, Wisconsin Heart Association, Wisconsin Hospital Association, and the American Cancer Society, Wisconsin Division. This money has assisted the Foundation's efforts in scientific medicine and education.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

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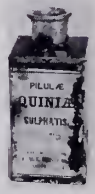

HISTORICAL ARTIFACTS

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It has been said, and truthfully:

"History is not only that which is hundreds of years old. History is today's events. They should be recorded for the time when they can be evaluated in the light of experience and impartiality."

THANKS

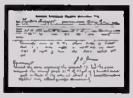
THE PENDARVIS HOUSE and DR. W. D. HAMLIN, Mineral Point, for these medicine bottles which came from one of the first pharmacies to be opened in this state, the R. D. Pulford Drug Store in Mineral Point.

The bottles, which are on view at the State Medical Society building, date back to around 1850 and were probably hand blown in a mold. One can see the mold markings and the area on the bottom of the vials where they were broken free of the mold. According to old newspaper files, the drug store from which they came was opened by Mr. Pulford in 1843 and operated by him until 1880. His reason for opening it may have been the fact that his father, S. Pulford, M.D., was a physicion. The lotter practiced in Mineral Paint from about 1840 to 1843, when he died at the age of about 52. Mr. Pulford, the druggist, specialized in several tonics and elixirs. One was Pulford's Bone, Joint and Bload Tonic—"Good for the Bones and Joints." No doubt the "tonics" were dispensed in bottles similar to these.

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS



MEDICAL MUSEUM

NEWS OF WISCONSIN PHYSICIANS

Dr. Engstrom Honored

Dr. William W. Engstrom of Milwaukee was one of 35 medical and dental scientists selected to receive the University of Minnesota's outstanding achievement award September 17 during the observance of the approximate centennial of the birth of the founders of the Mayo Clinic, Rochester, Minn. A specialist in internal medicine and endocrinology, Doctor Engstrom is professor and chairman of the Department of Medicine at Marquette University School of Medicine, Milwaukee.

Theda Clark Hospital Staff Announced

Dr. Frederick H. Smith has been elected president of the medical staff of Theda Clark Memorial Hospital in Neenah for a term ending June 30, 1965. *Dr. David M. Regan* was elected vice-president and *Dr. Harry J. Colgan*, secretary.

Named department chairmen at the hospital were *Dr. Vincent G. Springer*, clinical department of medicine; *Dr. F. N. Pansch*, reelected chairman of the clinical department of obstetrics and gynecology; and *Dr. Ralph L. Suechting*, clinical department of surgery.

Dr. Zimmermann Back from Ethiopia

Dr. and Mrs. F. H. Zimmerman have returned to their home in Watertown following a lengthy stay in Ethiopia.

Dr. Pisciotta Delivers Paper in Stockholm

Dr. Anthony Pisciotta of Elm Grove is a man of many interests, chief of which is hematology, a specialty he chose because of the opportunity it afforded of combining "working in the laboratory and seeing patients."

During a five-week tour of Europe this summer, made in company with his wife, Doctor Pisciotta delivered a paper before the International Congress of Hematology in Stockholm on his research into the effects certain drugs have on the bone marrow.

Doctor Pisciotta
Photo courtesy BROOKFIELD NEWS–ELM LEAVES

He became interested in hematology during his senior year at Marquette University School of Medicine, where he has taught his specialty for 12 years. He is now an associate professor of medicine at Marquette.

In addition to his avid interest in medicine, Doctor Pisciotta is an award-winning amateur photographer and a jazz and classical music fan. He and his wife left for Europe the last week in August and after the Stockholm convention, Doctor Pisciotta concentrated on photography during his travels to London, Norway, Denmark, and Italy.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Groessl at Green Bay

Dr. Peter J. Groessl has joined *Dr. Alvin Brusky* in general practice at Green Bay. He is a 1961 graduate of Marquette University School of Medicine.

Dr. Miner at Gundersen Clinic

Gundersen Clinic and La Crosse Lutheran Hospital have announced the association of Dr. Edward B. Miner. The new staff member received his M.D. degree in 1957 from the University of Wisconsin Medical School, and from 1962 until this past July, he was on active duty with the U.S. Public Health Service at the National Institutes of Health, Bethesda, Md., and the Outpatient Clinic, Washington, D.C. He was also on the faculty of George Washington University Medical School as an associate in physiology.

New Clinic Being Built at Oshkosh

Dec. 15 is the anticipated completion date of the new Oshkosh Clinic building on which work was commenced in August. Among those practicing in the new building will be *Dr. Harvey Monday*, president of the clinic corporation, *Drs. Harold J. Danforth* and *Thomas M. Kivlin*, general practice; *Dr. Benjamin S. Greenwood*, internal medicine; *Drs. Marvin H. Steen* and *William E. Clark*, general surgery; *Dr. Earl F. Cummings*, urology; *Dr. John T. Petersik*, psychiatry; *Drs. D. J. Ryan, R. F. Douglas*, and *S. Richard Beatty*, radiology; *Dr. Charles H. Behnke*, eye, ear, nose, and throat specialist; *Dr. Raymond V. Kuhn*, general practice and surgery.

Dr. Erdlitz Practicing in Mauston

Dr. F. J. Erdlitz, physician and surgeon, has opened an office for general practice in Mauston. A former Ontario physician, he spent about a month in La Valle before locating in Mauston.

Dr. Gillespie Joins Dr. Curran

Dr. Calvin J. Gillespie is now associated with *Dr. William P. Curran* in the practice of medicine and surgery at Antigo. A 1956 graduate of Marquette University School of Medicine, Milwaukee, Doctor Gillespie practiced in Antigo for several months following his discharge from the U.S. Air Force, in which he served two years. He is a fellow of the American College of Obstetricians and Gynecologists.

Dr. Kronquist Joins Pember Nuzum Clinic

Dr. Gordon E. Kronquist has joined the staff of The Pember Nuzum Clinic in Janesville, and is associated with *Dr. Katsumi Neeno* in the department of pediatrics. Doctor Kronquist received his M.D. degree from the University of Wisconsin, and after interning at St. Luke's Hospital, Cleveland, O., he joined the Naval Medical Corps and was attached to the Atlantic Reserve Fleet, Orange, Tex. Following his tour of duty, he returned to St. Luke's Hospital where he completed a pediatric residency.

Dr. Graham Receives Appointment

Dr. David T. Graham's appointment to the positions of acting assitant dean and director of admissions in the University of Wisconsin Medical School has been approved by U.W. regents. Doctor Graham, a specialist in psychosomatic medicine, was named to the medical school staff in July 1957 as an associate professor of medicine, and was made full professor in August 1963. He received his M.D. degree from Washington University in St. Louis in 1943, and for six years prior to joining the Wisconsin medical staff he held teaching positions in medicine and psychiatry at that university.

Dr. Ebert Writes on Africa

Dr. R. O. Ebert of Pine River, former longtime Oshkosh physician, is the author of a series of articles based on a trip made with members of the American Newspapers Study Missions, Inc. to the Portuguese overseas African provinces of Angola and Mozambique, as well as Morocco. The rapid modernization of the African continent was described by Doctor Ebert in an article in the OSHKOSH NORTHWESTERN. The Pine River doctor has traveled extensively, especially in the past five years, during which he has circled South America twice, been around the world, and to Africa twice.

New Faculty at UW Medical Center

Dr. W. Stuart Sykes, civilian anesthesiologist with USAFE in Swindon, England, for the past three years, has been appointed assistant professor of anesthesiology at the University of Wisconsin Medical School. He received his B.M. and B.Ch. degrees from Westminster Hospital and his M.D. degree in 1955 from Oxford University, England.

An appointment as assistant professor of pharmacology has been given to Dr. Bernard Weisblum, who was a postdoctoral fellow at Johns Hopkins during 1963–1964. He received his M.D. degree from State University of New York.

Dr. Henry P. Cappolillo has been appointed lecturer in psychiatry. Doctor Cappolillo has an M.D. degree from the University of Rome, Italy, and from 1959 to 1964, he was a fellow in child psychiatry and on the attending staff of Michael Reese Hospital in Chicago.

Appointments as instructors have been granted to Dr. Shi-Ming Chou, pathology, and *Dr. Gordon L. Eckert*, clinical instructor in gynecology and obstetrics. Doctor Chou received his M.D. degree from National Taiwan University Medical School; Doctor Eckert has an M.D. degree from the University of Wisconsin.

Dr. Albright Resigns

Dr. Edwin C. Albright resigned Sept. 1 as assistant dean for clinical affairs at the U.W. Medical School, a position he held for nearly three years.

Dr. Stephen Hull Joins Waupun Clinic

Dr. Stephen Hull has joined his father, *Dr. Harmon H. Hull*, and *Drs. C. P. Reslock* and *Rafael Barajas*, on the staff of the Waupun Clinic. A graduate of the University of Wisconsin Medical School, Doctor Hull completed his internship in July at Sioux Valley Hospital, Sioux Falls, S.D.

New Members of Lynn Clinic

New members of the Lynn Clinic in Green Bay are Drs. G. Robert Kaftan, pediatrician, and Roger L. von Heimburg, general and thoracic surgeon. Doctor Kaftan was attached to the U.S. Public Health Service Hospital in Talihina, Okla., for two years prior to coming to Green Bay. Doctor von Heimburg came to Green Bay from Rochester, Minn., where he spent six years in postgraduate training at the Mayo Clinic.

Dr. Cohill Joins Shawano Clinic

Dr. Donald F. Cohill has joined the staff of the Cantwell–Peterson Clinic at Shawano. Doctor Cohill was chief flight surgeon at Glasgow Air Force Base in Montana for two years before coming to Shawano. In May, at the annual Aero Space Medical Convention at Miami, Fla., he was presented with an award as Command Flight Surgeon of the Year 1963.

New Janesville Physician

A new Janesville physician is *Dr. Herman Nienhuis*, obstetrician and gynecologist, who is associated with *Dr. Robert A. Holland* at Doctors' Park, Janesville. Doctor Nienhuis and his wife and son moved to the state from Peru, Ind., where he served two years as chief of obstetrics and gynecology at Bunker Hill Air Force Base.

Dr. Myers Opens Practice at Durand

Durand has a new physician and surgeon in the person of Missouri-born Dr. Maurice Myers, who completed internship this past summer at St. Joseph's Hospital, Milwaukee.

Dr. Shahrokh Speaks on Deafness

In a recent talk before the Fond du Lac Rotary Club, *Dr. Darius K. Shahrokh* of the Fond du Lac Clinic explained some of the modern surgical treatments for deafness that he has been performing

Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

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Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae.*

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Cured with Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg ; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Brief Summary and Bibliography follow.

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since he received his master of science degree in otolaryngology at the University of Minnesota. Hearing loss, its causes and treatment, was Doctor Shahrokh's subject in another recent address before students of Marian College.

Physicians Appointed to SMS Divisions

The State Medical Society has announced the appointment of 28 Wisconsin physicians to serve on divisions of its Commission on State Departments. The commission, which works with governmental units concerned with health, has 10 divisions, each interested in a specific area of health.

Named to three-year terms are: AGING: *Drs. S. E. Sivertson*, LaCrosse; *W. C. Kleinpell*, Kenosha; *George M. Shinners*, Green Bay. CHEST DISEASES: *Drs. B. R. Lawton*, Marshfield; *W. J. Little*, Racine; *R. H. Wasserburger*, Madison. MATERNAL AND CHILD WELFARE: *Drs. F. G. Johnson*, Superior; *G. H. Stevens*, Wausau; *M. J. Olson*, Monroe; *K. F. Pelant*, Grafton. NERVOUS AND MENTAL DISEASES: *Drs. Henry Veit*, Milwaukee; *Edward E. Houfek*, Sheboygan; *J. T. Petersik*, Oshkosh; *G. B. Tybring*, Madison.

PUBLIC ASSISTANCE: *Drs. C. A. Olson*, Baldwin, and *W. W. Meyer*, Medford. HANDICAPPED CHILDREN: *Drs. Lloyd P. Williams*, Appleton; *Robin Allin*, Madison; *Ray R. Rueckert*, Portage. REHABILITATION: *Drs. Louis Kagen*, Milwaukee; *R. E. Housner*, Richland Center; *James F. McDermott*, Wauwatosa. SAFE TRANSPORTATION: *Dr. George Anderson*, Stevens Point. SCHOOL HEALTH: *Drs. E. E. Bertolaet*, West Allis, and *Rolf F. Poser*, Columbus. VISUAL AND HEARING DEFECTS: *Drs. Richard J. Fogle*, Racine; *James V. Bolger, Jr.*, Waukesha; *John B. Hitz*, Milwaukee.

Physicians Appointed to SMS Commissions

The State Medical Society has announced the appointment of 22 physicians to serve on its Commissions on Scientific Medicine, Public Policy and the Committee on Health Economics of American Life.

Appointed to the Commission on Public Policy, which reviews all state legislative proposals relating to health, were *Drs. Karl L. Siebecker, Jr.*, and *Henry A. Peters* of Madison; *Gerald O. Stubenrauch* and *John A. Kelble* of Milwaukee; *Robert L. Gilbert* and *Joseph B. Durst* of La Crosse; *James V. Bolger, Jr.* of Waukesha and *Paul K. Odlund* and *Samuel A. Freitag* of Janesville; *George M. Shinners* and *Jack A. Killins* of Green Bay; *Joseph L. Teresi*, Brookfield; *James S. Veum*, Appleton; *William W. Moir*, Sheboygan.

Five new members were appointed to the Commission on Scientific Medicine. They are *William T. Russell*, Sun Prairie; *Warren K. Simmons*, Rhinelander; *James L. Weygandt*, Sheboygan Falls and *Albert G. Martin*, Milwaukee, and *Ovid Meyer*, Madison.

The Commission on Scientific Medicine is responsible for all of the scientific programs conducted by the State Medical Society.

The Council also appointed three new members to the Committee on Health Economics of American Life. This committee reviews all federal health legislation for the medical society. The new members are *Drs. Albert M. Kohn*, Stevens Point; *L. H. Edelblute*, Green Bay, and *T. J. Doyle*, Superior.

Dr. Coffey Opens Waukesha Office

Dr. John M. Coffey has opened an office in Waukesha for the practice of obstetrics and gynecology. A 1957 graduate of Marquette University School of Medicine, Milwaukee, Doctor Coffey previously had offices in Milwaukee.

Photo courtesy SUPERIOR EVENING TELEGRAM

Superior Clinic Groundbreaking

Taking part in graundbreaking ceremonies at the site af the new Superior Clinic are, left to right abave, *Drs. I. H. Lavine, James McGill, Max Lavine*, and *Henry Sincack*, Mayor Charles Deneweth, *Dr. Fred Johnson, Dr. Enza Krahl*, and *Dr. Ralph Anderson*. Eight Superiar physicians assaciated with the new clinic, their wives, cantractars, and city afficiols took part in the ceremanies.

Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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PHYSICIAN NEWS *continued*

Dr. Sundstrom on Clinic's Staff

Dr. Walter R. Sundstrom, a 1957 graduate of Loyola Medical School, has joined the staff of the East Madison Clinic in Madison.

Dr. Stone Joins Giesen Clinic Staff

Dr. Richard Stone has joined the staff of the Giesen Clinic in Superior. A native of Grand Forks, N.D., Doctor Stone obtained his M.D. degree from Marquette University, Milwaukee.

Dr. Danforth Begins Practice

Former Janesville resident, Dr. R. Clarke Danforth, has recently become associated with *Dr. Francis J. Millen* in the practice of neurology, psychiatry, and electroencephalography in Milwaukee. He received his medical degree from the University of Wisconsin in Madison, where he took his residency in neurology at University Hospitals.

Dr. Schmidt at Menomonee Falls

Dr. Robert D. Schmidt is a recent addition to the staff of Medical Associates in Menomonee Falls. An obstetrician and gynecologist, Doctor Schmidt is a graduate of the University of Wisconsin Medical School, Madison.

Dr. Kloppedal in Prairie du Sac

Dr. Erling A. Kloppedal has joined the staff of *Drs. Paul Bishop* and *Gibbs W. Zauft* in Prairie du Sac. Prior to accepting the position in Prairie du Sac, Doctor Kloppedal practiced at Mendota State Hospital, Madison, and traveled extensively in Europe and the United States.

Dr. Natwick Joins Red Cedar Clinic

Dr. Roger D. Natwick, who completed a five-year surgical residency at St. Thomas Hospital, Akron, O., this past summer, is now associated with the medical staff of the Red Cedar Clinic in Menomonie. He is a 1958 graduate of Tufts University School of Medicine, Boston, Mass.

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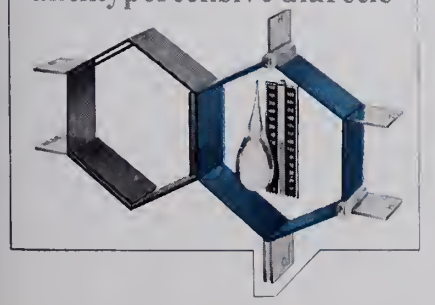

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INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1964 **Wisconsin**

Nov. 5, 12, 19–Dec. 3: Postgraduate course in "Fluid and Electrolyte Therapy," given by Marquette University School of Medicine in cooperation with Milwaukee Children's Hospital, Amphitheater, Milwaukee Children's Hospital, 1700 W. Wisconsin Ave., Milwaukee.

Nov. 11–12: Fourth annual Milwaukee Medical Conference, Milwaukee County Hospital, Milwaukee.

Nov. 14: Wisconsin Society of Pathologists, annual fall meeting, Marquette University School of Medicine, Milwaukee.

Nov. 14: Wisconsin Society of Obstetrics and Gynecology, 9 a.m. at St. Catherine's Hospital, Kenosha.

Nov. 16–18: Wisconsin Welfare Council, 83rd Annual Conference, Milwaukee.

Dec. 2: U. W. "In Depth" program—Pediatrics: "The Management of Common Childhood Anemias"—at University Hospitals and State Medical Society, Madison.

1965

Jan. 23–24: Triological Society, Wisconsin Center, Madison.

Jan. 28: U. W. "In Depth" program—Surgery: "Colon and Rectal Surgery in Children and Adults"—at University Hospitals and State Medical Society, Madison.

Feb. 17: U. W. "In Depth" program—Orthopedics: "Congenital Hips and Foot Deformities in Children" —at University Hospitals and State Medical Society, Madison.

Mar. 18: U. W. "In Depth" program—Obstetrics and Gynecology: "Endocrine Problems in Gynecology"—at University Hospitals and State Medical Society, Madison.

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

June: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

1964 **Out-of-State**

Oct. 1964–Mar. 1965: Biweekly courses in Continuing Education Program in Psychiatry and Psychotherapy, Mount Sinai Hospital, Chicago, Ill.

Nov. 2–6: American Nurses' Association, national conference, University of Chicago, Chicago, Ill.

Nov. 3–7: American Society of Oral Surgeons, 46th annual meeting, Las Vegas, Nev.

Nov. 7–8: National conference on disaster medical care, Chicago.

Nov. 9–12: Interstate Postgraduate Medical Assembly, Pittsburgh, Pa.

Nov. 9–13: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, International Inn, Washington, D. C.

Nov. 13–16: 1964 annual convention of National Society for Crippled Children and Adults, Statler–Hilton Hotel, Detroit, Mich.

Nov. 15: First national careers conference for youth, Cobo Hall, Civic Center, Detroit.

Nov. 16–20: American College of Physicians, postgraduate course No. 5, fundamental concepts of gastroenterology, University of Michigan Medical Center, Ann Arbor, Mich.

Nov. 16–18: 17th annual conference on Engineering in Medicine and Biology, Cleveland, Ohio.

Nov. 16–18: Section on Otolaryngology of the Southern Medical Association annual meeting, Memphis, Tenn.

Nov. 16–19: Section of Ophthalmology of the Southern Medical Association annual meeting, Memphis, Tenn.

Nov. 16–20: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, Barbizon Plaza Hotel, New York City.

Nov. 28–29: First national conference on areawide health facilities planning, sponsored by AMA Council on Medical Service, Americana Hotel, Bal Harbour, Fla.

Nov. 29: Sixth National Conference on the Medical Aspects of Sports, Miami Beach, Fla.,

Nov. 29–Dec. 2: American Medical Association, 18th clinical convention, Auditorium and Exposition Hall, Miami Beach, Fla.

Dec. 11–12: American Medical Association, conference on blood and blood banking, Drake Hotel, Chicago, Ill.

Dec. 14–16: Postgraduate Assembly in Anesthesiology, New York State Society of Anesthesiologists, Hilton Hotel, New York City.

1965

Jan. 4–8: American College of Physicians, postgraduate course No. 6, stroke and the cerebrovascular diseases, Rancho Los Amigos Hospital, Downey, Calif.

Jan. 17–23: University of Colorado School of Medicine, 11th annual general practice review, Denver.

Jan. 22–Feb. 4: International College of Surgeons, Caribbean surgical congress, aboard the S. S. Santa Paula, La Guaira, Curacao, Aruba, and Kingston.

Jan. 25–30: Workshop in Teratology, University of California, Berkeley.

Feb. 1–5: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, Hotel Fontainebleau, Miami Beach, Fla.

Feb. 10–13: American College of Radiology, Philadelphia, Pa.

Feb. 15–18: Medical Society of the State of New York, 159th annual convention, The Americana, New York City.

Feb. 15–19: American College of Physicians, postgraduate course No. 7, pathology, pathologic physiology, and clinical aspects of renal disease, Presbyterian–St. Luke's Hospital, Chicago, Ill.

Feb. 20–23: University of Utah College of Medicine, annual postgraduate course in anesthesiology, Salt Lake City.

March 15–20: University of Colorado School of Medicine, 6th postgraduate course in medical technology.

Mar. 28–Apr. 1: International Anesthesia Research Society, 39th congress, Washington, D. C.

Apr. 5–8: American College of Obstetricians and Gynecologists, annual clinical meeting, San Francisco, Calif. Postgraduate courses, Apr. 3–4.

Apr. 12–16: American College of Obstetricians and Gynecologists, Section of Hawaii, "Meeting on Maui."

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: American Medical Association, Section on Radiology, New York City.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

Correction

When Dr. D. Murray Angevine addresses the annual meeting of the Wisconsin Society of Pathologists Nov. 14 in Milwaukee, his subject will be "Late Effects of Radiation in Relation to Disease in Japan." In the August issue, it was reported that the University of Wisconsin professor would discuss "Recent Developments in Collagen Disorders."

American Nurses Association

Safety on the job and as part of the job of the occupational health nurse will be examined at the up-coming national conference sponsored by the American Nurses' Association November 2–6 at the University of Chicago, Chicago, Ill. The association's Occupational Health Nurses Section planned this third annual conference.

Occupational health nurses attending the five-day meeting at the University of Chicago's Center for Continuing Education will hear speakers from the National Safety Council, U.S. Public Health Service, Illinois Department of Labor, Inland Steel Company, Western Electric Company, and Employers Mutuals of Wausau. A special conference feature will be a field trip to the health facility at the Hawthorne works of Western Electric Company.

Postgraduate Course at Marquette

Marquette University School of Medicine in cooperation with Milwaukee Children's Hospital announces a postgraduate course in "Fluid and Electrolyte Therapy" on four Thursday evenings, November 5, 12, and 19 and December 3, from 7 to 9:30, in the Amphitheater of Milwaukee Children's Hospital, 1700 W. Wisconsin Avenue, Milwaukee.

Directors of the course will be Dr. Gerald A. Kerrigan, associate professor of pediatrics, and Dr. Edward J. Lennon, assistant professor of medicine and director of clinical research at Marquette.

Category I credit of 10 hours is offered by the American Academy of General Practice. Tuition will be $30.00 but there is no charge for residents, interns, or medical students.

Reservations should be made with Joseph W. Rastetter, M.D., Director Postgraduate Medical Education Programs, 8700 W. Wisconsin Ave., Milwaukee, Wis. 53226.

Second "In-Depth" Program at U.W.

The Department of Pediatrics of the University of Wisconsin Medical School will present a program on "Management of Common Childhood Anemias" at the University's second "In-Depth" one-day teaching program on Wednesday, December 2. Members of the department are developing the program in a manner which will be most helpful and practical to the family physician. Cases will be presented, and emphasis will be placed on diagnosis and treatment. Clinical and laboratory findings of representative patients will be demonstrated. Members of the department who will participate include Dr. Nathan J. Smith and Dr. L. Gilbert Thatcher.

A "wet clinic" will be held at 10 a.m. in Room 300, University Hospitals, 1300 University Avenue, Madison, with special parking for registrants at North Randall at 1400 University Avenue. Luncheon at 12:30 and the lecture program at 1:15 p.m. will be at the State Medical Society Building, 330 East Lakeside Street, Madison.

Full details may be obtained by writing Roy T. Ragatz, State Medical Society, Box 1109, Madison, Wis. 53701.

AMA Blood, Blood Banking Conference

The American Medical Association will sponsor a conference on blood and blood banking December 11–12 at the Drake Hotel, Chicago.

The conference is directed to practicing physicians, according to Dr. Gunnar Gundersen, LaCrosse, chairman of the AMA committee on blood, who expresses the hope that state and local medical societies will designate representatives to attend. It will be opened by Dr. Raymond L. White, Chicago, director of the AMA's division of environmental medicine and medical services, and by Doctor Gundersen. The latter announces that its objective is to "motivate the medical profession to evaluate and implement blood banking requirements and to participate generally in local blood banking affairs."

Further information may be obtained from the Department of Environmental Health, American Medical Association, 535 N. Dearborn St., Chicago.

ACP Postgraduate Program

"Stroke and the Cerebrovascular Diseases" will be featured January 4–8, 1965, when the American College of Physicians conducts its Course No. 6 at Rancho Los Amigos Hospital in Downey, Calif. The University of Southern California School of Medicine is cosponsoring the course, for which Dr. Charles D. Marple is director and Drs. Bertrand C. Kriete and Lloyd T. Iseri are codirectors.

Emphasis will be placed on the newer methods of diagnosis and treatment, both medical and surgical, and particularly on the rehabilitation of the person who has suffered a stroke. Prevention of complications will be stressed, including the prevention of contracture and decubiti in the hemiplegic patient.

Minimal registration is 100; maximal, 300.

Medical Technology Course

The University of Colorado School of Medicine announces the sixth postgraduate course in medical technology March 15–20, 1965, at Denver. Designed primarily for the medical technologist, this general course will cover the major phases of medical technology, with emphasis placed on practical aspects of laboratory work. New developments will be discussed. The course is being given in 1965 because construction and remodeling of the university's new Medical Center will make it impossible to offer it in

1966. When the school's facilities permit, a two-year schedule will be resumed.

For further information on the course, which is cosponsored by the Colorado Society of Medical Technologists, write to: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver, Colo. 80220.

WATA Annual Meeting

The Wisconsin Anti-Tuberculosis Association will hold its 1965 annual meeting April 1 and 2 at the Coach House Motor Inn, Milwaukee. Local association delegates and other special groups will begin meeting April 1, with the general sessions scheduled for April 2.

April 3, the Wisconsin Thoracic Society will meet.

Nomination of candidates for the WATA's 1965 distinguished service award may be sent to the Distinguished Service Award committee in care of the Wisconsin Anti-Tuberculosis Association, 1700 W. Wells St., Milwaukee.

ASIM To Meet in Atlantic City

In excess of 25 resolutions covering many areas of medical practice will be considered by delegates to the 8th annual meeting of the American Society of Internal Medicine April 3, 4, and 5, 1965, at the Claridge Hotel, Atlantic City, N. J. Wisconsin delegates are Dr. William L. Coffey, Jr., Milwaukee, and Dr. Leslie G. Kindschi, Monroe. Alternates are Dr. John H Wishart, Eau Claire, and Dr. George R. Barry, Monroe. Dr. Robert L. Gilbert, La Crosse, is an ASIM trustee.

Chest Physicians To Meet

The 31st annual meeting of the American College of Chest Physicians will be held June 17–21, 1965, at the Waldorf–Astoria Hotel, New York City.

The final day of the meeting, June 21, will be a combined session with the American College of Chest Physicians and the Section on Diseases of the Chest of the American Medical Association.

Sessions will include formal papers, symposia, roundtable luncheon discussions, and on June 21, during the combined AMA–ACCP meeting, the popular Fireside Conferences.

Mount Sinai Symposium, Head Injuries

Mount Sinai Hospital, Milwaukee, will hold a symposium on "Head Injuries and Concussive Syndromes" on Friday, November 6, in the Doctors' Auditorium. The third in a series of annual symposia on industrial injuries, the program is designed for industrialists, lawyers, and physicians faced with problems concerning on-the-job injuries.

Dr. Jules D. Levin is chairman of the symposium committee and will act as moderator of the panel discussion. Other speakers on the program include: Dr. Elisha S. Gurdjian, Detroit, professor of neurological surgery, Wayne University School of Medicine; Dr. Benjamin Boshes, Chicago, professor of neurology, Northwestern University School of Medicine; George Otto, a member of the Wisconsin Industrial Commission; Judge William I. O'Neill; attorney Arlo McKinnon; and attorney Kenneth Kasdorf, all of Milwaukee.

Members of the symposium committee are Drs. John Baker, Jean Davis, Lloyd F. Jenk, Allen E. Kagen, Arthur Litofsky, Jonas Mileras, Joseph A. Mufson, Bernard S. Schaeffer, and R. H. Strassburger.

Reservations for the all-day session may be made at the Mount Sinai medical office.

American Academy of Dermatology

The American Academy of Dermatology will hold its 23rd annual meeting at the Palmer House in Chicago, Ill., on December 5–10.

FOURTH ANNUAL MILWAUKEE MEDICAL CONFERENCE

Wednesday and Thursday—November 11 and 12, 1964

Coffey Memorial Auditorium—Milwaukee County Hospital

Sponsored by The Medical Society of Milwaukee County in cooperation with Marquette University School of Medicine and its teaching hospitals; Charitable, Educational and Scientific Foundation of State Medical Society of Wisconsin; Section VI, American College of Surgeons Committee on Trauma; Milwaukee County Hospital Intern-Resident Association; and Wisconsin Blue-Cross Surgical-Care Blue Shield.

REGISTRATION OPEN TO ALL PHYSICIANS. Registration fee: $5.00. No fee for medical students, interns, residents. Acceptable for 11 credit hours by American Academy of General Practice.

PROGRAM

WEDNESDAY, NOVEMBER 11

MEDICAL AND SURGICAL ASPECTS OF TRAUMA

Wednesday Morning Session

Program to be given by members of the Milwaukee County Hospital Intern-Resident Association, with all conference participants invited to attend.

Presiding: *Robert Feulner, M.D.*, President of the Milwaukee County Intern-Resident Association

9:00– 9:15	Endotoxin Shock—Treatment with Hyperbaric Oxygen, *William Evans, M.D.*
9:15– 9:30	Vascular Injuries, *Dudley Johnson, M.D.*
9:30– 9:45	The Initial Care of Hand Injuries, *Joseph Manago, M.D.*

9:45–10:00 Isolated Perfusion with an Extracorporeal Circuit—Its Use in the Treatment of Chronic Osteomyelitis, *Stuart Wilson, M.D.*

10:00–10:15 Head Injuries—The Role of Cerebral Angiography, *Sanford Larson, M.D.*

10:15–10:30 Diabetes Insipidus as a Result of Trauma—A Special Problem in Fluid Therapy, *John Petersen, M.D.*

10:30–10:45 Aramine Dependence—Prevention and Treatment, *James Botticelli, M.D.*

10:45–11:00 Management of Facial Injuries, *Paul Natvig, M.D.*

Wednesday Afternoon Session

12:30–12:45 Welcome—*Edwin H. Ellison, M.D.*, Chairman, program committee, The Medical Society of Milwaukee County *Harold E. Cook, M.D.*, Director, Medical Services, Milwaukee County Institutions

John S. Hirschboeck, M.D., Vice-President, Marquette University School of Medicine

Robert S. Haukohl, M.D., President, The Medical Society of Milwaukee County

I. THE INITIAL CARE OF THE TRAUMA PATIENT

Presiding: *Robert S. Haukohl, M.D.*

12:45– 1:00 Roadside First Aid and Transportation of the Injured, *Robert H. Kennedy, M.D.*, Director, Field Program Committee on Trauma, American College of Surgeons, New York, N. Y.

1:00– 1:20 Airway—Endotracheal Tube or Tracheostomy? *Jay Jacoby, M.D.*, Professor and Chrm., Dept. of Anesthesiology, Marquette University School of Medicine; Chrm., Dept of Anesthesiology, Milwaukee County Hospital; Consultant in Anesthesia, Wood Veterans Administration Hospital

1:20– 1:30 Film—Tracheostomy

1:30– 1:45 Intravenous Fluids in Initial Therapy, *Tom Shires, M.D.*, Professor and Chrm., Dept. of Surgery, University of Texas Southwestern Medical School, Dallas, Texas

1:45– 2:00 The Use of Vasopressors as the Initial Therapy of Shock, *Mark Nickerson, M.D., Ph.D.*, Professor and Head, Department of Pharmacology and Therapeutics, University of Manitoba, Winnipeg, Manitoba, Canada

2:00– 2:30 Triage and Evacuation Vs. Treatment and Consultation—An Application of Principles in the Initial Evaluation of the Injured Patient, *John A. Moncrief, Colonel, M.C.*, Commanding Officer and Director, U.S. Army Surgical Research Unit, Brooke Army Medical Center, Fort Sam Houston, Texas

2:30– 3:00 Coffee Break

3:00– 3:30 The Care of Fractures in the Emergency Room, *C. Hugh Hickey, M.D.*, Assistant Clinical Professor of Orthopedic Surgery, Marquette University School of Medicine

3:30– 3:45 The Diagnosis of Abdominal Injuries in the Emergency Room, *Joseph C. Darin, M.D.*, Assistant Professor of Surgery, Marquette University School of Medicine

3:45 –4:00 Management of Chest Injuries in the Emergency Room, *Leonard W. Worman, M.D.*, Assistant Professor of Thoracic and Cardiovascular Surgery, Marquette University School of Medicine; Director of Emergency Services, Milwaukee County Hospital

4:00– 4:30 Radiology in the Emergency Room, *Robert C. Feulner, M.D.*, Clinical Instructor in Radiology, Marquette University School of Medicine

4:30– 5:00 Discussion. Resuscitation—Methods, Mothering, Monitoring

Moderator: *Joseph C. Darin, M.D.*

Panel: *Robert H. Kennedy, M.D., Jay Jacoby, M.D., Tom Shires, M.D., Mark Nickerson, M.D., Ph.D., John A. Moncrief, Col., M.C.*

5:00 Adjournment

6:30 Reception—The Garden Terrace Room, Coach House Motor Inn, 1926 West Wisconsin Avenue.

THURSDAY, NOVEMBER 12

FIRST SESSION

II. THE CONTINUED CARE OF THE TRAUMA PATIENT

Presiding: *John A. Kelble, M.D.*, President, The Milwaukee Academy of General Practice

9:00– 9:30 Renal Function in Trauma—The Use of Mannitol, etc., *Edward Lennon, M.D.*, Assistant Professor of Medicine, Marquette University School of Medicine; Attending Staff, Milwaukee County Hospital

9:30–10:00 Fluid Therapy in Shock—The Use of Salt and Water, *Tom Shires, M.D.*

10:00–10:30 Drug Therapy in Shock—The Use of Vasodilators, *Mark Nickerson, M.D., Ph.D.*

10:30–10:45 Coffee Break

10:45–11:15 Discussion. Drug and Fluid Therapy in the Treatment of the Trauma Patient

Moderator: *Ramon L. Lange, M.D.*, Associate Professor of Medicine, Head of Cardiovascular Section, Marquette Division of Medicine; Attending Staff, Milwaukee County Hospital; Consultant in Radiology, Wood Veterans Administration Hospital

Panel: *James T. Botticelli, M.D.*, Instructor in Medicine, Marquette University School of Medicine, *Gerald A. Kerrigan, M.D.*, Associate Professor of Pediatrics, Marquette University School of Medicine, *Edward J. Lennon, M.D., John A. Moncrief, Col. M.C., Mark Nickerson, M.D., Ph.D., Tom Shires, M.D.*

SECOND SESSION

THE EMERGENCY ROOM

Presiding: *Frederick Bunkfeldt, Jr., M.D.* Chrm., Section 6, The Committee on Trauma, American College of Surgeons

11:15–11:30 The Role of the Modern Hospital Emergency Room, *Robert H. Kennedy, M.D.*

11:30–11:45 Behind the Scenes of a Major Disaster—The Indianapolis Coliseum Explosion, *Carl D. Martz, M.D.*, Clinical Professor in Orthopedic Surgery, Indiana University School of Medicine

11:45–12:15 Discussion. The Emergency Room—What it Means to the Physician, the Hospital, the Community

Moderator: *L. W. Worman, M.D.*

Panel: *Robert H. Kennedy, M.D., Tom Shires, M.D., Harold E. Cook, M.D., Mr. William E. Claypool*, Administrator West Allis (Wis.) Memorial Hospital, *Bernard Levinson, M.D.*, Director Medical Education, Mt. Sinai Hospital

12:15– 1:30 Luncheon

12:15– 1:30 Meeting of the American College of Surgeons Committee on Trauma, Section 6. Chairman: *Frederick Bunkfeldt, Jr., M.D.*

THURSDAY AFTERNOON SESSION

III. THE SPECIAL CARE OF THE TRAUMA PATIENT

Presiding: *Robert F. Purtell, M.D.*, President-Elect, The Medical Society of Milwaukee County

1:30– 2:00 The Burn Patient—A Special Problem in Trauma, *John A. Moncrief, Col., M.C.*

2:00– 3:00 Discussion. The Injured Child

Moderator: *Marvin Glicklich, M.D.*, Assistant Clinical Professor of Surgery, Marquette University School of Medicine

Panel: *Donald P. Babbitt, M.D.*, Assistant Clinical Professor in Radiology, Marquette University School of Medicine, *John Erbes, M.D.*, Clinical Instructor in Surgery, Marquette University School of Medicine, *Shimpei Sakaguchi, M.D.*, Assistant Clinical Professor of Surgery, Marquette University School of Medicine, *C. Randolph Turner, M.D.*, Clinical Instructor in Surgery, Marquette University School of Medicine

3:00– 3:15 The Team Physician and Athletic Injuries, *James A. Groh, M.D.*, Clinical Instructor in Orthopedic Surgery, Marquette University School of Medicine

3:15– 3:30 Heart Trauma—Recognition of Cardiac Tamponade or Impaired Venous Return, *Ramon L. Lange, M.D.*

3:30 Adjournment

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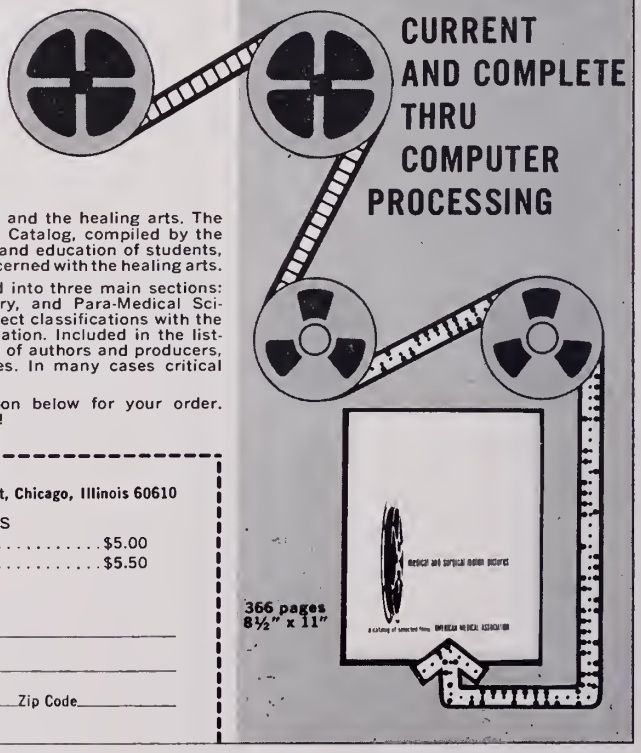

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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LETTERS

W. J. MEEK MEMORIAL FUND

To DOCTOR FALK:

I know that you will be interested to hear plans which have been made by the departmental committee for the use of the Walter J. Meek Memorial Fund. . . .

Perhaps you know that Mrs. Meek donated Doctor Meek's journals and books to the Medical School Library with the understanding that, as desired, they may be kept in the library of the Department of Physiology. The room which formerly was Doctor Meek's office is being used as the departmental library and each book or journal is being stamped: Department of Physiology, W. J. Meek Library. We have used a small portion of the Meek Memorial Fund to pay for binding volumes of the journals which were not bound previously and we shall keep up sets of American Journal of Physiology, Physiological Reviews, Annual Review of Physiology, Handbook of Physiology (published by the Amer. Physiol. Soc.) and The Journal of Physiology from this fund. Anyone who is concerned with medical research will recognize the great value that the staff and graduate students shall derive from having these publications at their finger tips rather than depending upon the library copies. These journals will not be checked out except over night. Also the binding of the journals as volumes accumulate will be paid for from the Meek Memorial Fund. In addition a few books used regularly by members of the department in their investigative work will be purchased. Persons not members of the department or students in physiology, of course, will be free to make use of these publications just as they would in the Medical Library.

It is anticipated that we shall be able to purchase the periodicals on the interest derived from the Meek Memorial Fund and hence will be able to keep up the subscriptions indefinitely. We hope that you will agree with us that this use of the fund will be of great help to the department and at the same time will be a continuing memorial to Doctor Meek.

W. B. YOUMANS
Department of Physiology
University of Wisconsin

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin, 53701.*

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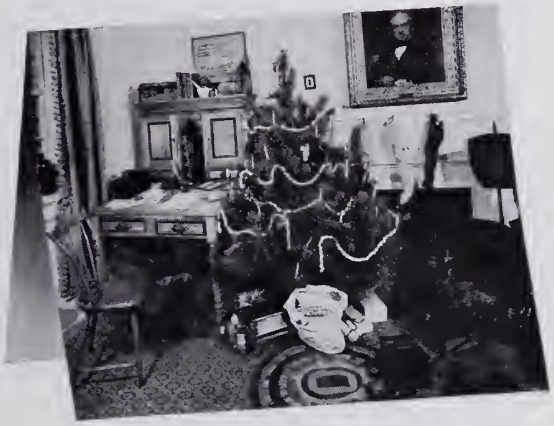

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OFFICIAL CALL
for Scientific Exhibits

1965 ANNUAL MEETING, MILWAUKEE, MAY 4–5–6

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1965 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1965 meeting are requested to file an application IMMEDIATELY, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Assignments made as exhibits approved by Commission on Scientific Medicine.*

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 8′ velour side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Spaces can be allocated in 10′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit IMMEDIATELY.
Address your communications to:

T. V. Geppert, M.D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison 1, Wisconsin

USE FORM ON OPPOSITE PAGE→

COUNTY SOCIETY PROCEEDINGS

BARRON–SAWYER–WASHBURN–BURNETT

"New Trends in the Diagnosis and Treatment of Coronary Artery Disease" was the theme of a paper presented by Dr. Carl Harrison of the Mayo Clinic, Rochester, Minn., at the October 13 meeting of the Barron–Sawyer–Washburn–Burnett County Medical Society. An attendance of 20 was reported at the meeting at the Country Inn, Rice Lake. A new member of the society is *Dr. K. C. Sun* of Siren.

BROWN

Dr. Clarence Gantt, assistant professor of medicine at the University of Illinois College of Medicine, Chicago, was the speaker for the October 8 meeting of the Brown County Medical Society. Doctor Gantt's topic for the meeting in the Walnut Room of Green Bay's Northland Hotel was "Endocrine Control of Renal Function."

DANE

Dr. Robert A. Straughn, Madison, new president of the Dane County Medical Society, assumed his duties at the society's annual meeting October 13 at the State Medical Society building, Madison.

New officers elected at the meeting were *Dr. Karl L. Siebecker*, president-elect; *Dr. C. K. Kincaid*, vice-president; and *Dr. John Morledge*, secretary-treasurer. Nominating committee members were *Drs. R. P. Sinaiko*, chairman, *John Curtis*, *John Mueller*, *W. P. Crowley, Jr.*, all of Madison; and *T. F. Heighway*, Middleton.

The society has four new members, all of whom are on the staff at University Hospitals, Madison. They are *Dr. John R. Benfield*, native of Vienna, Austria, and a 1955 graduate of the University of Chicago Medical School, who is an assistant professor of surgery at the hospitals; *Dr. John D. McMaster*, 1951 graduate of Temple University School of Medicine, assistant clinical professor of medicine and member of the staff of the Student Health Clinic; *Dr. Howard T. Rosenbaum*, graduate of State University of New York College of Medicine in 1957, assistant professor of radiology; and *Dr. L. Gilbert Thatcher*, University of Wisconsin Medical School graduate in 1955, assistant professor of pediatrics at the hospitals.

DOUGLAS

Robert Swanson, a psychiatric social worker who is assistant administrator of Catholic welfare, Diocese of Superior, and coordinator of the treatment center for emotionally disturbed children at St. Joseph's Children's Home, gave an interesting talk on this newly-opened unit at the September meeting of the Douglas County Medical Society. Setting for the meeting was the Saratoga Cafe, Superior.

Mr. Swanson emphasized that to operate the treatment center a large staff is necessary, consisting of a psychiatric consultant, psychiatric social worker, and psychologist, plus a large number of attendants and Sisters working on a fulltime basis.

Dr. C. J. Picard, Superior, reported on the annual session of the House of Delegates.

FOND DU LAC

At their annual meeting September 24 at the Elks Club in Fond du Lac, members of the Fond du Lac County Medical Society elected *Dr. Howard Mauthe* their president for 1965. Serving with him will be *Dr. William G. Kendell*, vice-president; and *Dr. John G. Parrish, Jr.*, secretary.

Following the election, *Dr. David J. Twohig, Jr.*, spoke on the (then) approaching House of Delegates meeting of the State Medical Society. *Dr. Herman R. Thomas, Jr.*, outlined plans for hospital staffing in the event of a community disaster. The society agreed to cosponsor a plan for public education in the field of mental health.

After hearing *Dr. Harold J. Kief*, president, review the minutes of a June 1962 meeting stating reasons why it was felt a change in the present school immunization program was needed, the society voted a recommendation to the public health agencies of Fond du Lac County that consideration be given regarding improvements in the present immunization program.

MARATHON

The Marathon County Medical Society joined with the Wisconsin Heart Association in sponsoring a rheumatic fever and congenital heart disease clinic October 15 at St. Mary's Hospital, Wausau. Attending physicians were *Dr. Joseph B. Grace*, internist, and *Dr. Richard L. Myers*, pediatrician, both of Green Bay. Twelve Marathon County children who had been referred by local physicians were examined.

The society selected, from seventh through ninth grade girls in the Wausau area schools, a "Miss Flame" who participated in Wausau's fire prevention week program early in October.

OZAUKEE

A seminar on religion and medicine featured the meeting of the Ozaukee County Medical Society October 22 at Smith Bros. Fish Shanty, Port Washington. Over 100 physicians, clergymen, and their wives attended the program which was arranged for the study and discussion of common concerns for the total welfare of the patient. Guests included members of the Washington County Medical Society, area clergymen of all faiths, and wives.

Physicians whose names appear in italic are members of the State Medical Society.

Host and chairman for the event was *Dr. K. F. Pelant*, Grafton, president of Ozaukee County Medical Society. Following a buffet dinner *Dr. P. B. Blanchard*, Cedarburg, district councilor, moderated the program and introduced the speakers.

Dr. R. E. Galasinski, Milwaukee surgeon, discussed "Unity in Treatment of the Patient by Physician and Clergy." He noted that illness is often a profound stimulus to the realization that man is more than just a material composite. It is in the stress of serious illness that the clergyman can and does help the physician in treating the sick, Doctor Galasinski stated. He stressed the need for absolute honesty between physician and patient, for people accept treatment far better and prepare themselves for the future with greater serenity if they know the truth.

The Rev. William H. Wallaik of the DeSales Seminary, Milwaukee, spoke on the subject "Maintaining Life—Ordinary and Extraordinary Means." Reverend Wallaik observed that medicine and the ministry have always been closely associated in the art of healing. The role of the physician is to maintain life; however, there is a point when life cannot be maintained. In terminal cases the physician should provide proper treatment and comfort for the patient, but extreme measures should not be used just to prolong life for a few more hours. Treatment in each case is a question of judgment and the decision may be difficult. He added that the wishes of the patient and his family should be considered, and a terminal patient should be allowed to die with decency and dignity.

The relationship between "Psychiatry and Religion" was discussed by Dr. Edward E. Houfek, Sheboygan psychiatrist. He stated that religion plays an important part in the mental health of the individual. Among psychiatric patients it is common to find a serious confusion about religious beliefs. He noted that some people have too great a fear of God and warned the clergy in presenting this view. Doctor Houfek said that clergymen can be of great help to psychiatrists in the treatment of mental illness, and should be alert to the symptoms of mental breakdown, such as severe depression, notable changes in behavior, confusion, loss of memory, behavior which endangers others, belief that others are watching him or plotting against him, talking to himself, and having grandiose ideas. He observed that our country has a successful suicide every 20 minutes, and 80 per cent of these offered advance warning.

The final speaker was Mr. Arne E. Larson, assistant director of the Department of Medicine and Religion of the American Medical Association, Chicago. He said that the department was established in 1961 to create a climate for communication between the physician and the clergyman that will lead to the most effective care and treatment of the patient. He indicated an increased need for this type of program to maintain the total health of man, which is now recognized to include four factors: physical, spiritual, mental, and social. Because of dramatic advances in medicine, modern drugs, and counseling procedures, members of the two professions often find themselves consulting with the patient or his family in regard to decisions involving life and death. Mr. Larson commended the Ozaukee County Medical Society for its efforts in presenting this program.

Following the speeches the group viewed the award-winning AMA film, "The One Who Heals," depicting situations in which physicians and clergy are both involved in the care of patients.

RACINE

The annual Christmas dinner dance of the Racine County Medical Society will be held December 8 at Racine Country Club. At the society's November 12 meeting at Wingspread, Father John Higgins of St. Louis University was guest speaker, on the theme, "Hypnosis in Modern Living."

New members of the society are *Dr. Donald Baumblatt*, Racine, who is in practice in internal medicine; *Dr. Brian T. Coffey*, who is associated with *Dr. Elizabeth A. Steffen*, Racine, in obstetrics and gynecology; *Dr. Stanley Englander*, pediatrician, who is associated with *Dr. Peter A. Gardetto*, Racine, at the Kurten Clinic; and *Dr. Marcial Martinez–Larre*, who is associated with *Dr. Samuel Faber*, Racine.

Dr. Arthur B. Grant, member of the Racine society, is in charge of donations for all Racine County physicians for the Racine United Fund Campaign. *Dr. Richard Minton* is head of a committee to study the feasibility of a plan proposed by Union leadership in Racine to sponsor an annual screening clinic at all factories to rule out common diseases. After studying the idea, the committee will meet with United Fund and Union representatives to discuss it.

WINNEBAGO

Dr. Ethan B. Pfefferkorn, Oshkosh, was program chairman for the October meeting of the Winnebago County Medical Society on the first of the month at the Raulf Hotel, Oshkosh. Doctor Pfefferkorn presented a film entitled "Cancer Detection Examination in the Doctor's Office."

OUTAGAMIE COUNTY

A recent management survey of Outagamie county institutions has concluded that the county must consolidate its medical facilities and at the same time prepare to meet mounting community needs for additional facilities.

COLUMBIA COUNTY

A home nursing care program will be offered in Columbia county beginning next year as the result of a recommendation developed by the county's health and education committee with the help of the State Board of Health and the State Medical Society.

Photo courtesy MARSHFIELD NEWS-HERALD

WOOD

DR. JAMES R. HEERSMA, representing the Waad Caunty Medical Society, presents Marshfield City Nurse Elaine Chandler with a $300 audiameter ta be used in the audiametrics testing program which started in October in Grades 1–4–7–10 in public and parachial schaals of Marshfield. The society presented identical machines ta the City af Wiscansin Rapids and to Woad Caunty. Maney ta pay for the audiometers came from the society's share of proceeds fram last winter's oral polia vaccine pragram.

UW School of Nursing

A new graduate program leading to a master of science degree with specialization in pediatric nursing has been established by the University of Wisconsin School of Nursing at Madison, Dean Helen L. Bunge recently announced. The program will be supported by a grant from the Children's Bureau of the Division of Health Services, Department of Health, Education and Welfare. The first five students in the program enrolled in September.

"Our purpose is to prepare pediatric nurse specialists for positions of responsibility and leadership in the field of maternal and child health," said Florence G. Blake, director of the new project. Miss Blake said there is a critical need for practicing nurses to take major responsibility both in nursing service and nursing education. The new program, she added, will prepare practitioners for this type of responsibility.

The two-year program will prepare students for teaching or clinical specialization, but the program is focused on pediatric nursing, Miss Blake said. Students are admitted for full-time study at the beginning of each fall semester. Admission requirements include those of the University Graduate School and the School of Nursing. It is anticipated that some traineeships will be available from the Children's Bureau to help some of the students.

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State Medical Record Librarians

The Wisconsin Association of Medical Record Librarians will be hostess to the American Association of Medical Record Librarians in the fall of 1966, it was announced at the annual meeting of the state group held recently in Milwaukee.

Elected president during the two-day sessions was Sister M. Petrone, director of the School for Medical Record Librarians in Wisconsin and chief medical record librarian at St. Francis Hospital, La Crosse. Also elected were Ruth King, Milwaukee, vice-president; Sister M. Danile, Milwaukee, secretary; and Patricia Pruden, Milwaukee, treasurer.

Stroke-Nursing Seminar

A stroke-nursing seminar sponsored by the Wisconsin Heart Association's Fond du Lac County division was held Sept. 30 at St. Agnes School of Nursing, Fond du Lac. *Dr. Hanno Mayer,* Milwaukee internist and a member of the heart association's board of directors, was the principal speaker. His topic, "Prevention of Disability from Stroke," was the subject of a panel discussion.

State Sanatorium Meeting

Dr. Oscar Farias of Superior, medical director at Middle River Sanatorium, was selected as vice-president of the Wisconsin Sanatorium Superintendents Association at that group's annual meeting September 18 at Stevens Point. The meeting was held jointly with the Wisconsin Sanatorium Trustees Association. One of the speakers was *Dr. Raymond H. Evers,* superintendent and medical director of Sheboygan County's Rocky Knoll Sanatorium and Hospital.

Dietetic Association

Drs. F. N. Lohrenz and *James Vedder* of the Marshfield Clinic were speakers at the annual meeting of the Northern Wisconsin Dietetic Association September 25 at Mead Inn, Wisconsin Rapids. Doctor Lohrenz spoke on "Newer Concepts in Treatment of Diabetes." Doctor Vedder discussed his experiences as pediatrician aboard the SS Hope in Peru.

Heart Conference at Appleton

Planned by the Outagamie County division, Wisconsin Heart Association, was a conference held October 8 in Appleton to make businessmen aware of heart disease as "number one killer and health enemy." Among those who addressed the gathering were *Dr. George Hellmuth,* Hartford, whose subject was "Heart Disease and the Law—A One Year Study of the Wisconsin Industrial Commission over the Last 10 Years," and *Dr. Jack Anderson,* Appleton, president of the Outagamie County Medical Society, who discussed "The Working Cardiac."

Physicians whose names appear in italic are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Rock County Medical Assistants

New officers of the Rock County Medical Assistants, installed at the group's October meeting at the Corral, Beloit, are: Mrs. Donald Clayton, president; Mrs. John Spahos, president-elect; Mrs. Kay Lutton, secretary; Miss Marilyn Watson, treasurer. Presiding was Mrs. Charles Matthews.

Wisconsin Society of Internal Medicine

Dr. George E. Gutmann, Janesville, was installed as president of the Wisconsin Society of Internal Medicine at the organization's annual meeting October 9–10 at Delavan. *Dr. A. A. Quisling,* Madison, was named president-elect, and *Dr. John H. Wishart,* Eau Claire, was reelected secretary-treasurer. *Dr. William G. Kendell,* Fond du Lac, was elected to a three-year term on the board of governors.

Dermatological Societies

Marshfield was the setting, September 12, for a joint clinic held by the Minnesota and Wisconsin Dermatological Societies. *Dr. Stephan Epstein* of the Marshfield Clinic presided, assisted by the presidents of the two state societies, *Dr. Daniel E. Hackbarth* of Milwaukee and Dr. Harold Perry of Rochester, Minn. The dermatological staff of the Marshfield Clinic had charge of the program.

In addition to dermatologists from the two adjoining states, including chiefs of the dermatological departments of the Universities of Minnesota, Wisconsin, and Marquette University, and staff members from the Mayo Clinic, Rochester, Minn., there were representatives present from such widely separate countries as Canada and Indonesia.

Douglas County Medical Assistants

The newly-formed Douglas County Medical Assistants Society has announced its officers, elected at an organizational luncheon meeting held at Cronstrom's Supper Club, Superior, in September. Mrs. Marian Baker is the president; Mrs. Louise Cohn, president-elect; Mrs. Mildred Neimann, treasurer; and Mrs. Hortense Manley, recording secretary. The group has 15 charter members.

Waukesha County Medical Assistants

Five hundred hats were up for sale when the Waukesha County Medical Assistants Society held its annual hat sale for charity September 16 at St. Mary's gymnasium in Waukesha. Mrs. John A. Gedakovitz, Town of Waukesha, was in charge.

SPECIALTY PROCEEDINGS *continued*

Cardiac Patient Discussed

A special one-half day conference, sponsored by the Dane County Unit of the Wisconsin Heart Association with the cooperation of the Madison Chamber of Commerce and the State Medical Society of Wisconsin, was held October 20 at the State Medical Society building, Madison.

Purpose of the conference was to discuss the cardiac patient and his employment. Guest speakers included Dr. Earle A. Irvin, medical director, Ford Motor Company; Nathan P. Feinsinger, professor of law, University of Wisconsin Law School, Madison, and *Dr. Richard H. Wasserburger*, chief of cardiology at the Madison Veterans Administration Hospital. Topics discussed included "The Cardiac Can Work," "Labor Relations and the Cardiac," "Vocational Rehabilitation of the Cardiac," "Insurance Carriers and the Cardiac," and "Heart Disease and Workmen's Compensation."

Milwaukee Academy of Medicine

Dr. Carl A. Moyer, head of the Department of Surgery at Washington University School of Medicine, St. Louis, Mo., was the speaker at the 982nd meeting of the Milwaukee Academy of Medicine October 20 at the University Club of Milwaukee. His subject was "Relationship of Blood Volumes of Human Beings and Animals to the Sodium Mass of the Body."

The academy's next meeting was announced for November 17, with Dr. Jack W. Crowell, Department of Physiology, University of Mississippi Medical Center, as the speaker.

Dodge County Medical Assistants

The fine points of good telephone communication were presented at the October 6 meeting of the Dodge County Medical Assistants Society. Guest speaker was Mrs. Helen Prange, business service counselor of the Wisconsin Telephone Company.

At the society's opening meeting, in September, Mrs. Madeline Stebbins, president, outlined activities planned for the fall and early winter months. The Beaver Dam plant of the Green Giant Company was the setting for the meeting, with Marvin Keil, Green Giant district personnel manager, as the guest speaker.

Open Panel Lists of Physicians Released

Workmen's Compensation panels, listing physicians in each county who treat cases of industrial illness or injury, have been sent to more than 80,000 employers by the State Medical Society. The listings, first issued in 1939, are sent out every three years at a cost of more than $12,000 by the Society.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Teplin Promoted

Dr. Ervin Teplin of Milwaukee was promoted in August to the post of associate clinical professor of psychiatry at Marquette University School of Medicine. The same month, he was reappointed as assistant clinical professor of psychiatry at the University of Wisconsin Medical School.

Dr. Peterman Goes to Washington

Dr. M. G. Peterman terminated his private practice in Milwaukee November 1 to move to Washington, D. C., where he will be associated with the Bureau of Medicine, Food and Drug Administration, Department of Health, Education and Welfare.

Hemophilia Group Honors Dr. Quick

A reception honoring *Dr. Armand J. Quick*, emeritus professor and chairman of the department of biochemistry at Marquette University School of Medicine and a world authority on blood coagulation and bleeding diseases, was held September 27 at Blatz Pavilion, Lincoln Park, Milwaukee, by the Wisconsin chapter of the National Hemophilia Foundation.

Clinic Founder Attends Dinner

Dr. R. P. Potter, 85, surviving member of the six doctors who founded the Marshfield Clinic late in 1916, was among the guests at the dinner sponsored by the clinic in cooperation with the Marshfield Clinic Foundation for Medical Education and Research September 26.

Photo courtesy WAUKESHA DAILY FREEMAN

Waukesha Group Discusses Cancer

WAUKESHA COUNTY PHYSICIANS and nurses held a meeting in early October to discuss the latest methods of cancer treatment. Shown at the meeting (left to right) are Dr. John M. Coffey, Brookfield; Dr. Eugene E. Zwisler, Mukwonago; R. O. McLean, Madison, ex-director of the Wisconsin Division of the American Cancer Society, and Dr. R. James Rasmussen, Waukesha. Doctor Coffey is chairman of the professional information committee. Doctor Zwisler is president of the Waukesha County unit of the American Cancer Society and Doctor Rasmussen is service chairman of the Waukesha County cancer group.

Physicians whose names appear in italics are members of the State Medical Society.

UW Doctors Science Speakers

Drs. Jerzy E. Rose and Clinton N. Woolsey of the University of Wisconsin faculty were among the speakers at the annual fall meeting of the National Academy of Sciences October 12–14 at the University of Wisconsin, Madison. Doctor Rose was one of the scientists who reported on their research into the nature of the activity of the hearing nerves. Doctor Woolsey acted as convenor for the hearing symposium.

Fund Section Headed by Dr. Vastola

Dr. A. P. Vastola, Jr., Madison, served as chairman of the physicians' section of the professional division of Madison's 1964 United Givers Fund.

New ACS Fellows

Sixteen Wisconsin physicians were among the approximately 1,125 surgeons inducted as new fellows of the American College of Surgeons October 8 during the college's 50th Annual Clinical Congress at Chicago.

Receiving the distinction were *Drs. Vernon H. Bartley*, Eagle River; *Donald A. Smith*, Fond du Lac; *George J. Theiler, Jr.*, Green Bay; *George B. Murphy, Jr.*, La Crosse; *John R. Benfield* and *Robert O. Johnson*, Madison; *Robert J. Banker*, Manitowoc; *Alfred E. Kritter*, Waukesha; *Richard D. Sautter*, Marshfield; *James R. Keuer*, Medford; *William E. Finlayson, George F. Flynn, Benjamin G. Narodick, Arthur A. Rand, Allen J. Savitt*, and *Leonard W. Worman*, Milwaukee.

Dr. Cochrane at Three Lakes

After serving for 19 years in Beloit, *Dr. William L. Cochrane* has established a practice in Three Lakes. His wife, a registered nurse, is serving with her husband in the Three Lakes Clinic.

Dr. Treffert Heads State Hospital

Since October 1, Dr. Darold A. Treffert has been superintendent of Winnebago State Hospital, Oshkosh. His appointment was announced by Wilbur J. Schmidt, director of the State Department of Public Welfare. Doctor Treffert had been acting superintendent of the hospital since May. He joined its staff in July 1962 as chief of the children and adolescents unit, organized to serve the increasing number of patients under 18.

Dr. Busse Honored

Dr. A. A. Busse, 80, Jefferson, was honored in mid-September for 50 years of medical service to his community. Previously honored by the State Medical Society, the Jefferson physician is still practicing medicine. He has served as president of the American College of Chest Physicians and governor for the Wisconsin College of Chest Physicians and also as president of the Jefferson County Medical Society.

Marquette–Jackson Clinic Program

Eighty physicians from Wisconsin and northern Illinois attended the thirty-fourth annual postgraduate meeting sponsored by the Marquette University School of Medicine, Milwaukee, and the Jackson Clinic, Madison, October 1 at the Park Motor Inn, Madison.

Dr. Luther E. Holmgren, president of the Jackson Clinic, welcomed the group and introduced the speakers.

Speakers from the Jackson Clinic and their topics were: *Dr. Oscar F. Foscid*, Department of Surgery, "Pneumothorax—Diagnosis and Surgical Treatment;" *Dr. Barbara A. Brew*, Department of Obstetrics and Gynecology, "Hemorrhage Complicating Delivery;" and *Dr. William J. McAweeney*, Department of Internal Medicine, "The Serum Sodium."

Marquette speakers were: *Dr. Jacob Lemann*, Department of Medicine, "Some Aspects of Hypercalcemia;" Dr. David W. Kersting, Chairman, Department of Dermatology, "Bullous and Vesicular Dermatoses;" and *Dr. Edward S. Friedrichs*, Departments of Medicine and Psychiatry, "Obesity—Metabolic and Psychophysiologic Aspects."

A panel was presented on "Pneumonias—Diagnosis and Treatment." Participants were *Drs. D. William Hurst, Hubert C. Ashman, William L. Waskow*, and moderator, *Dr. John H. Morledge*. Doctor Waskow is radiologist at the Jackson Clinic; the other panelists and moderator are members of the Department of Internal Medicine.

Following a social hour and dinner in the evening, Mr. Robert D. Zucker of Merrill, Lynch, Pierce, Fenner & Smith, Milwaukee, addressed the group on the subject "The Psychology of the Stock Market."

Dr. Angell at Eau Claire

Dr. David Clark Angell, former instructor in the department of pathology at the University of Michigan, has become associated with *Dr. Robert J. Fink* in the practice of pathology at Sacred Heart Hospital, Eau Claire. Doctor Angell, who received his M.D. degree from McGill University, Montreal, Canada, is certified by the American Board of Pathology in both pathologic anatomy and clinical pathology.

Joins Tigerton Clinic

Dr. R. J. Winkler is the new associate of *Dr. L. F. Heise* at the Tigerton Hospital and Clinic. Doctor Winkler practiced in Hilbert for 30 years and spent five years in military service. The past five years he had been with the Veterans Administration Centers at Wood and Tomah and the Milwaukee County Hospital.

Dr. Acheson Heads Staff

Dr. William E. Acheson, Valders, is the newly-elected president of the medical staff of Holy Family Hospital, Manitowoc. Elected with him were *Dr. D. A. Kuljis*, Mishicot, vice-president; and *Dr. J. E. Nilles*, Mishicot, secretary-treasurer. Serving on the executive committee are *Drs. W. C. Randolph, N. S. Davis, Jr.*, and *R. F. Thorpe*, Manitowoc.

Dr. Schwab Joins Dells Clinic

Dr. Donald F. Schwab has joined the staff of the Dells Clinic at Wisconsin Dells. A 1961 graduate of the University of Wisconsin Medical School, he interned at Madison General Hospital and for the last two years had been in general practice in Madison.

AAUW Branch Hears Dr. Lanier

Dr. Patricia Lanier, Kewaunee, president of the Wisconsin state division of the American Association of University Women, was speaker for the opening meeting of the Watertown branch of the AAUW on September 23. Her subject for the dinner meeting at the Blew Inn, Watertown, was "The High Challenge."

Doctor Lanier, who has been in general practice since 1950 with her husband, *Dr. Andrew Lanier*, has achieved a notable record in her profession. Her activities have included presidency of Door–Kewaunee County Medical Society in 1963 and membership on several commissions and divisions of the State Medical Society.

Dr. Balzer Opens Oak Creek Office

Dr. Rudolph Balzer, Milwaukee physician since 1960, has opened an office for general practice in Oak Creek. He is affiliated with St. Luke's and Doctor's Hospitals and is expected to return to the Trinity Memorial Hospital staff.

Dr. Frank on Teachers Program

Dr. Ralph C. Frank, Eau Claire radiologist and former president of the Wisconsin division of the American Cancer Society, addressed the convention of the North Wisconsin-Lake Superior Education Association early in October at Ashland. Doctor Frank used slides to illustrate his talk on "Cancer Control."

Drs. Krygier, Kienzle Relocate

Since November 1, *Drs. W. L. Krygier* and *C. J. Kienzle* have been located at 1107 West Oklahoma Avenue, Milwaukee.

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Dr. Mattingly Awarded Grant

Dr. Richard F. Mattingly, Milwaukee, has received a grant of $14,990 for continuing work in cancer research, the Milwaukee division of the American Cancer Society has announced. Doctor Mattingly, who is professor and chairman of the department of gynecology and obstetrics at Marquette University School of Medicine, is studying the radiosensitivity of cancer of the cervix.

Diabetes Group Hears Dr. Niebauer

Dr. W. E. Niebauer, Phillips physician and one of three medical advisers of the Price County Lay Diabetes Association, explained the causes and effects of diabetes and methods of control at a recent meeting of the group.

Hear Fond du Lac Physicians

Dr. R. W. Schroeder was guest speaker for the October 7 meeting of the Childbirth Education Association, Inc., at St. Agnes Hospital cafeteria, Fond du Lac. His subject was "Sex Education for Young Children." At the group's September meeting, another Fond du Lac physician, *Dr. John U. Peters*, was the speaker, on the topic, "Toilet Training and Feeding Problems."

Dr. Eckert Joins Quisling Clinic

Dr. Gordon L. Eckert, gynecologist and obstetrician, has joined the Quisling Clinic in Madison. He is affiliated with University Hospitals as a clinical instructor.

Dr. Miller Gives Building to Clintonville

Dr. and Mrs. E. A. Miller, Clintonville, have given the City of Clintonville a two-story brick building on Main street. The structure has been vacant since Doctor Miller's retirement in 1960 at the age of 90, after 64 years of practice.

Dr. Kelley Helps Alma Mater

Dr. Orville R. Kelley, Wausau, has been named to a committee heading a three-year drive to raise $1,250,000 for a new medical library for the University of Virginia.

Dr. Samp Is Speaker

Dr. Robert J. Samp, assistant professor of surgery in the clinical oncology division, University of Wisconsin Medical School, was the speaker for the Tri-County Inservice meeting early in September at Rhinelander Union High School. Some 300 teachers heard him discuss the topic, "The Facts of Life for Tri-County Teachers, Both High School and Elementary."

Dr. Curreri Receives Appointment

Dr. Anthony R. Curreri, director of the division of clinical oncology at the University of Wisconsin Medical School, has been appointed to the clinical studies panel of the National Cancer Institute for a year.

Dr. Hirschboeck Speaks

Dr. John S. Hirschboeck, acting dean and vice-president of Marquette University School of Medicine, opened the program October 3 when alumnae of Marquette met at the school's College of Nursing to participate in a program with the theme, "What's New for Women in Medicine?". Doctor Hirschboeck's subject was "Careers for Women in Medicine." *Dr. Carol Latorraca*, Milwaukee anesthesiologist, was one of two speakers providing supplementary comments on the same topic.

Dr. Hitselberger Transfers

Dr. James F. Hitselberger, former Fond du Lac dermatologist, has moved to Oshkosh where he has acquired the practice of the late Dr. Ernest A. Strakosch.

Joins Gundersen Clinic Staff

The Gundersen Clinic, La Crosse, has announced the association of Dr. A. Erik Gundersen, specialist in pediatric, thoracic, and cardiac surgery.

MU Medical School Deficit

The Marquette University School of Medicine incurred a deficit of $296,406 in the fiscal year that ended last June 30, the school's board of directors reported in October. Expenditures totaled $4,227,505. The previous year's deficit was $70,437, and the total medical school operating deficit now stands at $2,302,700. Of this, $1,278,068 is owed to the university, from which the medical school has borrowed. The university, in turn, has borrowed from lending institutions.

Clergy—Physician Seminar

Physicians and clergymen gathered together recently to talk shop at the Marquette University College of Nursing, Milwaukee. Introductory remarks were made by *Dr. Thomas C. Puchner*, chairman of the planning committee, who keynoted the purpose of the seminar by saying "Clergymen and physicians can cooperate to bring more effective service to the public and prevent some forms of disabling functional states, and to counsel anxious families."

A featured speaker at the seminar was the Rev. Paul A. Qualben, M.D., director of the mental health service of the Lutheran Medical Center, Brooklyn, N. Y. On the program also was *Dr. Hanno Mayer*, an internist and chairman of the Milwaukee Heart unit. The seminar was sponsored by the Milwaukee unit of the Wisconsin Heart Association.

Visiting Professor at UW

Dr. J. Lawrence Pool, professor and chairman of the Department of Neurological Surgery, Columbia University College of Physicians and Surgeons, New York City, was Helen Halverson visiting pro-

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fessor of neurological surgery from November 16 to November 21 at the University of Wisconsin Medical School, Madison. He delivered a number of lectures to medical students, house staff, and faculty including the medical school convocation at noon November 19 in S.M.I. auditorium entitled "Management of Intracranial Aneurysms and Arteriovenous Malformations." The visiting professorship is provided by Mr. Harold F. Halverson and family of Beloit in memory of Mrs. Helen Halverson.

Dr. Siebecker on ASA Panel

Dr. Karl L. Siebecker, Madison, served as moderator for a panel discussion on "Pulmonary Physiological Facts for the Clinician" October 12 during the annual meeting of the American Society of Anesthesiologists at the Americana Hotel, Bal Harbour, Fla. On October 14, Doctor Siebecker was a member of a panel entitled "Questions Please." He is professor and chairman of the Department of Anesthesiology at the University of Wisconsin Medical School.

Dr. Teeter Named Director

Dr. Richard R. Teeter, current director of outpatient services at Milwaukee Psychiatric Hospital and associate professor of psychiatry at Marquette University School of Medicine, has been named director of residency training for the Associated Psychiatric Training Program of Milwaukee, which encompasses several organizations: Milwaukee Psychiatric Hospital (formerly Milwaukee Sanitarium), Veterans Administration Hospital at Wood, Milwaukee Children's Hospital and Marquette University School of Medicine.

Dr. Middleton Heads Drive

Dr. William S. Middleton, Madison, has accepted the state chairmanship for the Wisconsin Heart Association's 1965 Heart Fund campaign which will be held in February. News of his acceptance was made public by *Dr. William B. Hildebrand*, Menasha, WHA president.

Dr. Gerstle Has Guest from Germany

Dr. Reinhard Albrecht, medical director of Deutsche Philips Company in Wetzlar/Lahn, West Germany, was the late summer guest of *Dr. Walter J. Gerstle* of Kenosha, medical director of American Motors Corporation.

Group Hears Dr. Pavlic

Dr. Robert S. Pavlic, Brookfield physician, spoke on "Extra-Sensory Perception" at the September 16 meeting of Milwaukee alumnae of Gamma Phi Beta sorority. The Elm Grove home of Mrs. Frank H. Urban was the setting for the meeting.

Dr. O'Meara Conducts Program

Dr. Mark T. O'Meara of Grandview Clinic and Hospital, La Crosse, conducted a training session on external cardiac massage at the September 2 meeting of the Coulee Region Kiwanis Club, La Crosse.

Photo courtesy DURAND COURIER-WEDGE

Joseph P. Springer, M.D.

Dr. Springer Serves on HOPE

A TWO-MONTH TOUR OF DUTY with the White Hospital Ship HOPE is ahead for Dr. Joseph P. Springer. The Durand doctor is leaving Dec. 12 to fly from New York to Conakry, Guinea, West Africa, where the HOPE will be berthed while its rotating staff teaches some 200 doctors from the general area. Doctor Springer considers an assignment to the HOPE on its present voyage a particular challenge. In West Africa, three million people are served by only 80 physicians, merely 10 of whom are considered reasonably competent. In the entire area there are no public health facilities, and tropical diseases are rampant. Infant mortality ranges up to 75 per cent and the life span of the natives seldom exceeds 30 years. Chartered in 1960 by People to People Health Foundation, the HOPE carries a permanent staff of physicians, nurses, and other medical personnel which is complemented by the rotating staff. All the American medical staff serves without salary. The ship's name is an abbreviation for Health Opportunity for People Everywhere.

State Health Officer Neupert Resigns

Dr. William T. Clark, president of the State Board of Health, announced October 23 the resignation of *Dr. Carl N. Neupert* as state health officer, effective June 1, 1965, and the appointment by the Board of *Dr. E. H. Jorris*, presently assistant state health officer, as state health officer.

In resigning, Doctor Neupert ends a 29-year career with the State Board of Health. Born in London, Wis., in 1897, he graduated from Stout Institute in Menomonie, Wis., and completed his premedical work at the University of Wisconsin. He served as an Ensign in World War I. He received his M.D. from the Washington University School of Medicine and his M.S.P.H. degree from

the University of Michigan School of Public Health. Doctor Neupert is also a diplomate of the American Board of Preventive Medicine and Public Health.

Prior to joining the Board of Health in 1936, Doctor Neupert practiced medicine in Janesville for ten years. In 1939, he was appointed assistant state health officer, a position which he held until his appointment as Wisconsin's fourth state health officer in 1943. As state health officer, he has also served as secretary to the Board.

Doctor Neupert was health chairman of the National Congress of Parents and Teachers from 1950 to 1953, and a member of the National Education Association and American Medical Association Joint Committee on Health Problems in Education from 1949 to 1953, serving as chairman from 1952 to 1953.

He is a member of the Dane County and Wisconsin medical societies and of the American Medical Association; a fellow of the American Public Health Association; a member and past president of the Conference of State and Provincial Health Authorities of North America, and also a member and past president of the Association of State and Territorial Health Officers; a member of Middle States Health Association; of the Wisconsin Association for Public Health and of the Wisconsin Public Health Council. He is a member of the Wisconsin Association of Public Health Physicians and also of the American Association of Public Health Physicians.

Doctor Jorris was born in La Crosse, Wis., and holds his M.D. from the University of Minnesota. He also has an M.S.P.H. degree from the University of Michigan School of Public Health and is a diplomate of the American Board of Preventive Medicine and Public Health.

He joined the State Board of Health in 1936 as a district health officer in Sparta. In 1941 he came to Madison to assume the directorship of the section for local health services. From 1943 to 1946 Doctor Jorris served as a Commander in the United States Navy. Upon his return in 1946, he was appointed assistant state health officer, the position in which he will continue until June 1, 1965, when he assumes the duties of state health officer.

Doctor Jorris is a member of the Dane County and Wisconsin medical societies, and of the American Medical Association; a fellow of the American Public Health Association; a member of the Middle States Health Association, of the Wisconsin Association of Public Health, and of the Wisconsin Public Health Council. He is also a member of the Wisconsin Association of Public Health Physicians, the American Association of Public Health Physicians, and the American College of Preventive Medicine.

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PHYSICIAN NEWS *continued*

Marshfield Doctors Present Program

Pulmonary embolectomy, a rare operation which has been successfully performed three times at Marshfield, was described by a trio of Marshfield physicians in September at the Pembine Conference of Wisconsin, Michigan, and Minnesota chest physicians. Presenting the program on the subject were *Drs. Ben R. Lawton* on the surgical, *George E. Magnin* on the medical, and *Dean Emanuel* on the diagnostic aspect.

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Iowa Physician Demonstrates Computer Possibilities at SMS Headquarters

The State Medical Society's 1440 computer, in the WPS accounting department, may someday share its accounting ability with diagnosis of disease. This was the basis of a demonstration held in October at the Society headquarters in Madison.

Dr. John Gustafson, a staff member at Iowa Methodist Hospital in Des Moines, has been studying the use of computers in diagnosis under a $300,000 grant from the John A. Hartford Foundation. The Madison demonstration was arranged by Dr. Mark C. Hansen, the University of Wisconsin Medical School, the IBM Corp., and the State Medical Society.

USE OF THE COMPUTER for diagnosis of disease was demonstrated at the State Medical Society headquarters recently by Dr. John Gustafson, an Iowa pediatrician. He is shown above in the right center. Dr. Herman H. Shapira, professor of clinical medicine at the University of Wisconsin Medical School, is at the left center.

Doctor Gustafson told the group of physicians that the computer can become a monumental time-saver for the doctor and quite likely a life-saver for patients with out-of-the-ordinary afflictions. In essence, the properly programed computer does in minutes the work of hours for a trained scientist. In the application Doctor Gustafson has worked out, the computer scans a welter of facts stored in its mechanical brain and produces a diagnosis based on information obtained by the doctor from the patient.

Diagnosis by computer may be only five years away, Doctor Gustafson said. Doctor Gustafson routinely uses the computer in analyzing congenital heart ailments. Use of the machine for prescribing is still in the experimental stage, but the Iowa doctor figures this area would be a natural for the computer.

McArdle Laboratory Dedicated

The new eleven-story McArdle Laboratory for Cancer Research of the University of Wisconsin's Medical School was dedicated October 17. The $3 million laboratory, located just south of the University Children's Hospital, contains 96,000 square feet of space to be devoted to cancer research. The old McArdle Laboratory had 25,000 square feet.

The new laboratory was financed largely by a grant from the National Cancer Institute. The McArdle Laboratory is the largest of 14 such facilities which have been built throughout the country.

At present there are 10 permanent faculty members at McArdle, each in charge of his own research program. In addition, there are two research associates, one instructor, 24 postdoctoral fellows, and 20 graduate students. Additional technical and other assistants make a total staff of about 130 persons. Dr. Harold P. Rusch is the director.

Rotarians Hear Dr. Wolberg

"There has been a recent breakthrough in cancer research," *Dr. William H. Wolberg*, Madison cancer specialist in chemical research, told Fort Atkinson Rotarians late in the summer at the club's weekly meeting at Koshkonong Mounds Country Club.

Dr. Gallagher Berlin Speaker

Dr. William Gallagher of the Skemp Clinic, La Crosse, showed slides and told of his experiences while serving aboard the White Hospital Ship HOPE in Peru on September 23 at the Clay Lamberton School in Berlin.

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Photo courtesy KENOSHA NEWS

Doctor Welsch, Kenosha, Honored

DR. R. G. WELSCH, Kenosha physician (right) receives a plaque from the Kenosha Education Association honoring him for his work in organizing and directing the Sabin oral vaccine campaign in Kenosha and Kenosha County. Making the presentation are Gerald Euting (left), president of KEA, and Malcolm Young, chairman of the organization's professional rights and responsibilities committee.

Fox Lake Has New Doctors

Since October 1, the Fox Lake community has had two new physicians, Drs. Edward C. Ferguson and *Lance G. G. Glasson.* They have taken the place of *Dr. William H. Snook,* who became associated with *Dr. E. Robert Taake* November 1 at Beaver Dam, and *Dr. William J. Duxbury,* who is now practicing in a West Coast city.

Both Doctors Ferguson and Glasson are graduates of Marquette University School of Medicine. Since 1960 Doctor Glasson has been a diplomate of the American Board of Surgery. Doctor Ferguson has completed all the required training for acceptance by the same board. He formerly practiced at Waupun and Juneau. Before locating in Fox Lake, Doctor Glasson practiced in Miami, Fla., Tucson, Ariz., and Reedsburg.

Teaching Programs Scheduled For State Physicians

On October 29 the first of a series of five "in-depth" teaching programs for practicing physicians was held at the University Hospitals in cooperation with the State Medical Society of Wisconsin and the Madison Chapter of the Wisconsin Academy of General Practice.

The full day's program October 29, was on dermatology and allergy. Featured as guest speakers were Dr. Frank Perlman, Portland, Ore., and *Dr. Stephan Epstein,* Marshfield. In addition, *Drs. Sture A. M. Johnson* and *Charles Reed,* members of the departments of dermatology and allergy at University Hospitals, Madison, participated.

On December 2 a full day will be devoted to pediatrics. Three more days scheduled early next year will be on surgery, orthopedics, and gynecology.

The programs, designed especially for the general practitioner, begin with physician attendance at the University Hospitals in the morning sessions. The luncheon and lecture programs in the afternoon are held at State Medical Society headquarters, 330 East Lakeside Street, in Madison.

Marshfield Clinic Adds Three

New additions to the Marshfield Clinic staff are Dr. Warren J. Holtey, anesthesiologist, Dr. Gerald R. Marschke, allergist, and Dr. Stephen E. Silvis, internist.

Doctor Holtey, who received his medical degree in 1959 from Johns Hopkins University in Baltimore, served as a captain in the Army Medical Corps during the two years prior to July 4 of this year. Doctor Marschke, a 1955 graduate of the University of Minnesota Medical School, since 1962 had been specializing in allergy work at the UCLA Medical Center, Los Angeles. Doctor Silvis also graduated from the University of Minnesota Medical School in 1955. He came to Marshfield from the Veterans Administration Hospital in Minneapolis, where he was a resident in gastroenterology.

Dr. Simenstad with Dean Clinic

Dr. Paul O. Simenstad, internist, has joined the Dean Clinic in Madison. A 1954 graduate of the University of Rochester School of Medicine, Rochester, N. Y., Doctor Simenstad became a diplomate of the American College of Internal Medicine in 1963, and was engaged in private practice in Osceola from 1962 through July, 1964.

Club Hears Dr. Collentine

Dr. George E. Collentine, Jr., Whitefish Bay, spoke on the subject, "Medicare and You," at a meeting of the 18th ward Republican Club September 22 at the Mill Inn, Milwaukee.

Dr. Vogel Gives Talks

Dr. Thorn L. Vogel, Janesville city health commissioner, conducted a series of talks for girls 10 to 14 years old and their mothers in October and November at Franklin Junior High School, Janesville.

Dr. Monday Heads Mercy Staff

Dr. Harvey Monday was elected president of the medical staff of Mercy Hospital, Oshkosh, at the hospital's annual business meeting in September. Named heads of departments were *Dr. John A. Leschke,* obstetrics; *Dr. John B. Hughes,* medicine; *Dr. Paul S. Emrich,* surgery.

CANCER SURVIVAL RATES have improved from 1937's rate of one in seven to today's one in three. Early diagnosis, better surgical and radiological techniques and more than a dozen new therapeutic agents are responsible.

OBITUARIES

Dr. Evan E. Carl, retired Beaver Dam and Milwaukee physician, died May 29, 1964, at the age of 76.

Born in Nichols, Iowa, Doctor Carl received his medical degree in 1916 from Iowa State University and interned at North Chicago Hospital, Chicago. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, American Medical Association, and the Academy of Ophthalmology and Otolaryngology.

Dr. Victor J. Taugher, Berlin physician known for his work in medical hypnosis, died July 11, 1964, at the age of 72.

A native of St. Nazianz, Doctor Taugher was granted his M.D. degree in 1919 by Marquette University School of Medicine, and did postgraduate work at New York Lying-in Hospital for one year. He practiced in Marathon from 1919 to 1924 when he located in Milwaukee, where he was an instructor in obstetrics and gynecology at Marquette for four years, and was also an instructor in obstetrics at Misericordia Hospital. He practiced obstetrics and gynecology in Milwaukee until 1949 when he moved to Berlin.

He was a life fellow of the Seminars on Hypnosis Foundation, a fellow of the Academy of Psychosomatic Medicine, an honorary member of the British Medical Hypnotists, and a member of the American Society of Clinical Hypnosis, the Green Lake–Waushara County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Those surviving include his widow, Therese; two daughters, Mrs. Patricia Hekkers, Waukesha, and Mrs. Monine McConnell, Green Lake; and six sons, Terrence, Hartford; Donald, West Allis; Robert, New Berlin; Victor, Castro Valley, Calif.; Richard, Waukesha; and Brian, Oshkosh.

Dr. Earl E. Carpenter, a native of Superior, died in that city July 13, 1964, at the age of 65.

A 1925 graduate of Rush Medical School, Chicago, Doctor Carpenter interned at St. Mary's Hospital, Superior, where he also served his residency. In 1945 he was superintendent of the Middle River Sanatorium, and in 1947, he served as president of the medical staff of St. Joseph's Hospital, Superior.

Organizations in which Doctor Carpenter was a member include the Douglas County Medical Association, the State Medical Society of Wisconsin, the American Medical Association, American College of Chest Physicians, and American College of Allergists. He saw active service with the infantry in 1918.

Survivors include a son, Earl E., Jr., Superior.

Dr. Walter P. Zmyslony, Milwaukee, died July 19, 1964, at the age of 68.

He was born in Milwaukee, where he received his medical degree in 1925 from Marquette University School of Medicine. He served his internship at St. Mary's and Mercy Hospital, Oshkosh.

Doctor Zmyslony had served as school physician for the Milwaukee Health Department and he was on the staff of St. Luke's and St. Francis Hospitals in Milwaukee. He had served as secretary-treasurer of St. Luke's. He was a former president of the Polish Medical and Dental Association of Milwaukee, and a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, the American Academy of General Practice, and the International Academy of Proctology. He had also served on Selective Service Examining Board No. 14. He held the rank of colonel in the inactive Medical Reserve.

Surviving are his widow, Laura, and a daughter and son, Mrs. Edward Kasperski and James.

Dr. John H. Karsten, native of Horicon and second in a line of three generations of physicians who have served the Horicon community since 1893, died July 28, 1964, at the age of 68. He had been retired for a year.

Doctor Karsten served with Base Hospital No. 41 at St. Denis, France, for a year prior to entering Marquette University School of Medicine, where he was granted his M.D. degree in 1923. That same year he entered practice with his father, the late Dr. Adrian C. Karsten.

He was a member and past president of the Dodge County Medical Society, a member of the State Medical Society of Wisconsin, American Medical Association, and in addition he was active in the American Cancer Society, American Heart Association, American Red Cross, and many other organizations. He had served as health officer for the City of Horicon and Town of Hubbard, as a Selective Service examiner, and in other capacities.

Surviving are his widow, Catherine, and three children, Dr. Fred A., Horicon; Mrs. William Sutherland, Janesville; and Mrs. John Fabke, Corning, N. Y.

Dr. William A. Werrell died August 14, 1964, at the age of 70.

Doctor Werrell received his M.D. degree in 1927 from the University of Wisconsin Medical School and served both his internship and residency at University Hospitals. Since 1938 he had been executive secretary-treasurer of the American Board of Internal Medicine, and from 1936 to 1939 he was a member of the Wisconsin Industrial Commission Heating and Ventilating Code committee, representing the State Medical Society on that body. He was a past president of the Dane County Medical Society, a member of its credentials committee, and a member of the State Medical Society of Wisconsin and the American Medical Association. He was also a veteran of World War I.

Two brothers survive. They are: Col. (Ret.) Angus J. Werrell, Greeley, Colo., and Roy H., Denver, Colo.

Dr. Jesse W. Shaw, 50, an associate of the Manitowoc Clinic, died August 25, 1964.

A physician's son, he was born in St. Louis, Mo., and attended St. Louis University School of Medicine, where he received his doctor's degree in 1939. He interned at St. Mary's Group Hospitals of St. Louis University and served a residency at St. Mary's Hospital, Madison. From 1941 to 1947 he practiced at Carbondale, Ill., with time out to serve, from October 1941 until February 1946, as a flight surgeon with the Army Air Force in North Africa, Italy, France, and Germany.

After practicing for two years at Menard, Ill., he completed his residency at the Veterans Administration Hospital at Hines, Ill. In 1951 he joined the Manitowoc Clinic. He was a member and past president of the staff of Manitowoc Memorial Hospital and a member of the staff of Holy Family Hospital, Manitowoc.

A diplomate of the American Board of Urology, Doctor Shaw was named president-elect, in April of 1964, of the Wisconsin State Urological Society. He was also a member of the North Central Section of the American Urological Association, the Manitowoc County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

Among his survivors are his widow, Daunene, and three children, Susan, Sara, and David, at home.

Dr. Mary Peebles Gratiot, a Shullsburg physician for 40 years and a lifelong Shullsburg resident, died September 4, 1964, at the age of 93.

She was the widow of Dr. Charles Gratiot, a Shullsburg physician in whose office she began her medical career in 1903. She liked her work so well that she attended the Illinois Medical College, Chicago, and in 1908 passed her state board examinations to become one of the handful of women then practicing medicine in the Midwest. She proceeded to become something of a legend when in 1918 she worked around the clock to combat a flu epidemic in New Diggings.

In 1958, "Doctor Mary" was the only woman among the 20 physicians honored with membership in the "50 Year Club" of the State Medical Society of Wisconsin. She was also a member of the Lafayette County Medical Society and the American Medical Association, and for many years she was health officer in her community.

Reprinted from the HORICON REPORTER, August 6, 1964

Judge Traeger Writes Personal Tribute on Death of Old Friend

PERSONALLY, in Doctor John H. Karsten, M.D., I had my closest friend and confident, having been associated with him for 31 years; he in the practice of Medicine and I in the practice of Law.

I am at a loss to describe in words the greatness of this Country Doctor—his greatness came in so many ways.

Under the influence of his grandfather, a Dutch Reform Church minister . . . he was instilled with an unselfish and charitable Christian understanding of men that no other man in our day possesses.

The influence of his doctor father, Adrian C. Karsten, M.D., who gave his life to service above self for the people of Horicon and vicinity also guided him along that same pathway of service.

Doctor John was generous in the giving of himself to service for others. The question of renumeration (sic) never entered his mind. His accomplishments for the betterment of his patients and other citizens generally, provided his greatest satisfaction.

. . . Doctor John was a great believer in preventative medicine. Early in his career, he took up the work of preventive medicine by providing programs of vaccination and inoculations which required great sacrifice. School children were provided protection without cost from the dreaded children diseases. Red Cross Training Programs were set up and life saving training was provided the Horicon Fire Department. How many hours of his life were given freely to this effort is unknown, but I do know that no human being will surpass him in this regard.

Doctor John served his country at a base hospital near the front lines in France with long, weary and tiring hours. He also gave himself to the services of this country during World War II by way of an examining physician for the boys going into service. As City Health Officer over a long period of time, he conscientiously applied his knowledge for the protection of the citizenry.

The moral fibre of Doctor John was of the highest caliber. The influence of his morality was felt by many. During my twelve years as District Attorney, Dodge County felt the result of his moral influence upon me. I can only say now—would that I could be as morally strong as he.

I write this message with tears of sorrow at his passing and I respectfully submit that he was God's gift to Horicon and its most valuable citizen. I am sure he has earned a heavenly reward.

Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF SEPTEMBER 10, 1964

NEW MEMBERS

John R. Allen, 1 West Wilson Street, Madison.
Luca Alverno, 1570 North Prospect Avenue, Milwaukee.
Neil L. Barber, 10425 West North Avenue, Milwaukee.
Philip A. Bond, 5024 North Kent, Milwaukee.
Michael W. Bottum, 10691 West Parnell Avenue, Hales Corners.
William M. Buzogany, 4721 Regent Street, Madison.
Andrew B. Crummy, Jr., 1300 University Avenue, Madison.
LeRoy A. Ecklund, 301 Troy Drive, Madison.
Jerome W. Fons, Jr., 8017 West Scranton Place, Milwaukee.
V. A. Giannattasio, 161 West Wisconsin Avenue, Milwaukee.
Thomas M. Golbert, V.A. Hospital, Wood.
Richard A. Graf, 1219 Regent Street, Madison.
Helen J. Gurkow, 195 East Main Street, Platteville.
Donald H. Holder, 1298 North 63rd Street, Milwaukee.
William A. Kisken, 1300 University Avenue, Madison.
Walter A. Lauvstad, Marshfield Clinic, Marshfield.
Rudolf W. Link, 1446 West Skyline Drive, Madison.
Arthur Litofsky, 161 West Wisconsin Avenue, Milwaukee.
Thomas C. Meyer, 1300 University Avenue, Madison 6.
Frank E. Murray, 2212 West State Street, Milwaukee.
Anthony Joseph Pace, R.F.D. #2, Eagle River.
Frederick M. Rich, 110 East Main Street, Madison.
Arthur A. Siebens, 1954 East Washington Avenue, Madison.
James R. Slamer, 720 East Wisconsin Avenue, Milwaukee.
Nicholas P. Staves, 6210 West Greenfield Avenue, Milwaukee.
Bernhardt E. Stein, 1300 University Avenue, Madison 6.
Paul C. Tregoning, 2020 East Milwaukee Street, Janesville.
M. A. Von Gradulewski, P.O. Box 68, Necedah.
James A. Wenders, 10427 West National Avenue, Milwaukee.

CHANGES OF ADDRESS WITHIN THE CITY

A. D. Anderson, 4634 Tokay Boulevard, Madison.
Richard M. Asma, 8200 North Teutonia Avenue, Milwaukee 53209.
Donald P. Babbitt, 1700 West Wisconsin Avenue, Milwaukee.
Louis L. Bensman, 8700 West Wisconsin Avenue, Milwaukee.
Milton C. Bessiere, 4203 Monona Drive, Madison.
Arnold Bliwas, 2007 16th Street, Racine.
Harold F. Borenz, 1404 University Avenue, Madison.
William M. Brown, Jr., 3646 Canon Boulevard, Altadena, Calif. 91002.
Thurl C. Burr, Jr., 400 Strollers Lane, Wausau.
Gerald L. Clinton, 2712 Marshall Court, Madison.
Thayer C. Davis, 108 North Lincoln Avenue, Beaver Dam.
S. Doubrava, Jr., 2764 North 117th Place, Milwaukee 53222.
Aubrey A. Drescher, Red Cedar Clinic, Menomonie.
Richard H. Driessel, P.O. Box 408, West Bend.
William S. Dunn, 802 South Baldwin Street, Madison.
C. C. Edmondson, 717 North East Avenue, Waukesha.
John R. Erickson, 211 Water Street, Stevens Point.
Henry C. Everett, 109 Chestnut Street, Madison.
C. E. Fenlon, 420 East Longview Drive, Appleton.
John Fetherston, Sr., 6900 North Port Washington Road, Milwaukee.
John P. Fetherston, Jr., 6900 North Port Washington Road, Milwaukee.
John R. Fuller, 2216 Fifth Street, Monroe.
Horace S. Fuson, 420 Bellinger Street, Eau Claire.
Jack E. Geist, 161 West Wisconsin Avenue, Milwaukee.
Nathan A. Gendlin, 1470 Standish Place, Milwaukee.
T. J. Goral, 34810 Pabst Road, Oconomowoc.
A. L. Gundersen, R. #2, Ebners Coulee, La Crosse.
George H. Handy, 441 Mead Circle, Wisconsin Rapids.
Margaret E. Hatfield, 611 56th Street, Kenosha.
Thomas E. Henney, 310 West Conant Street, Portage.
Lawrence A. Howards, 2305 West Woodbury Lane, Milwaukee.
Dorsey W. Hurst, 3126 Grandview Boulevard, Madison 11.
Donald G. Ives, 409 East Silver Spring Drive, Milwaukee.
Raymond S. Jobling, 1343 West Wisconsin Avenue, Milwaukee.
Robert L. Johnson, 831 4th Street South, Wisconsin Rapids.
Leo G. Joseph, 308 Exchange Building, La Crosse.
Alex M. Kane, 2356 North Grant Boulevard, Milwaukee.
Robert A. Keller, 718 South 27th Street, Sheboygan.
Wendell A. Killins, 525 Arrowhead Drive, Green Bay.
Martin M. Kleiman, 8736 West Palmetto Avenue, Milwaukee.
Milton G. Klumb, 6533 West Center Street, Milwaukee.
Clarence E. Kozarek, 325 Butts Avenue, Tomah.
Michael J. Kuhn, 5500 West Capitol Drive, Milwaukee.
Michael J. Kuhn, Jr., 5500 West Capitol Drive, Milwaukee.
Ralph B. Lenz, 371 Main Avenue, West De Pere.
Baldwin E. Lloyd, 134 North Leonard Street, West Salem.
John D. Maloney, 2123 Ridgeview Road, Columbus, Ohio 43221.
W. H. Marsden, 906 Edgewater Court, Madison.
Norbert A. McGreane, 112 East Ann Street, Darlington.
Gale L. Mendeloff, 9420 North Spruce Road, Milwaukee 17.
Peter A. H. Midelfart, 321 Summit Avenue, Eau Claire.
David L. Morris, 134 North Leonard Street, West Salem.
John P. Mullooly, 8430 West Capitol Drive, Milwaukee.
John T. Murphy, V.A. Hospital, Columbia, South Carolina.
F. A. Nause, 1720 North 8th Street, Sheboygan.
James R. Nellen, 8221 West Oklahoma Avenue, Milwaukee.

Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections*, all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Cured with Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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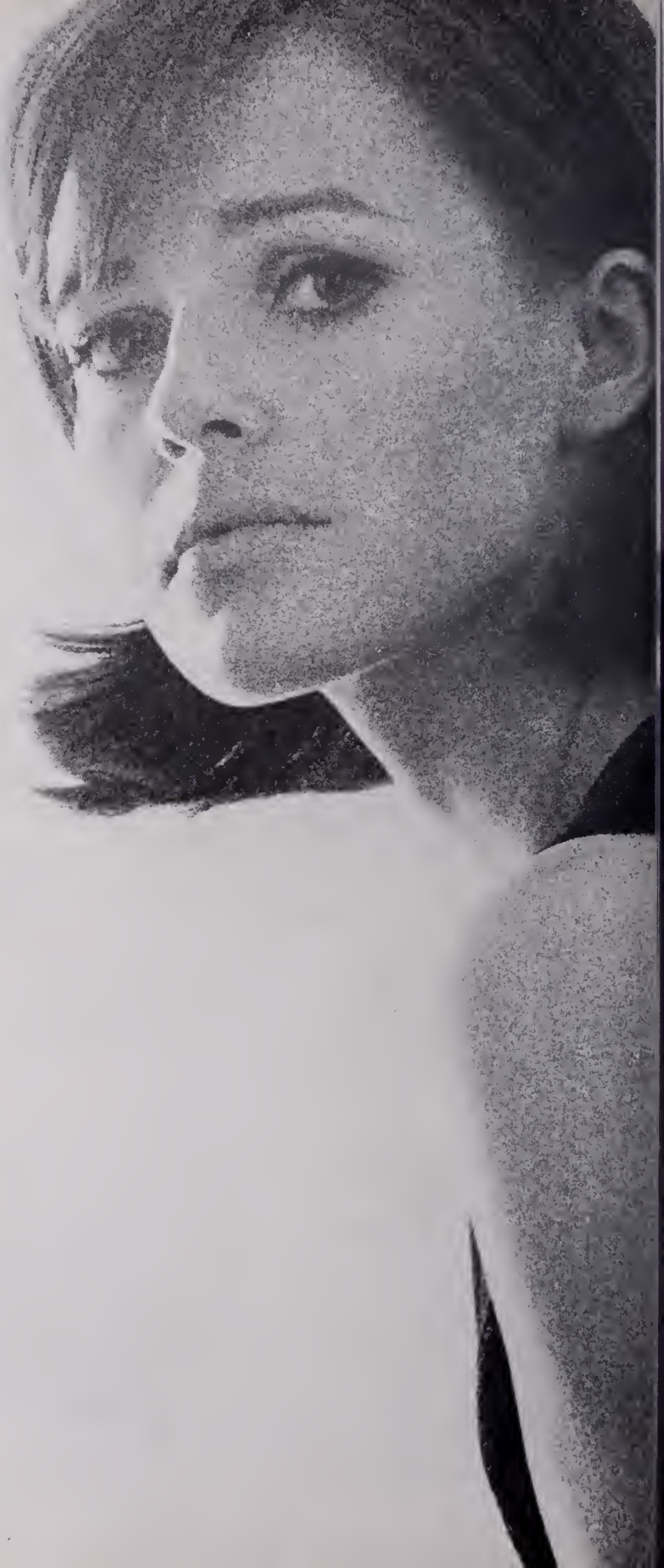
too young to be so tired...



revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:

Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.

Alcohol 15%

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ...available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

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Donald L. Wood, Wauwatosa, to 17400 West North Avenue, Northbrook Building, Brookfield.

Loren J. Yount, New Berlin, to S67 W12927 Larkspur Road, Hales Corners.

Richard E. Zellmer, Elm Grove, to 2500 West 108th Street, Wauwatosa.

REMOVED FROM MEMBERSHIP

Bruce E. Greenfield, Rock County.

Donna H. Larson, Milwaukee County, resigned.

John A. Lind, Barron-Washburn-Sawyer-Burnett County.

Elvine M. Thomas, Waukesha County.

John P. Walker, Trempealeau-Jackson-Buffalo County.

DEATHS

Victor J. Taugher, Green Lake-Waushara County, July 11, 1964.
Earl E. Carpenter, Douglas County, July 13, 1964.
Leo W. Egloff, nonmember, July 16, 1964.
Walter P. Zmyslony, Milwaukee County, July 19, 1964.
Louis J. Bennett, nonmember, July 21, 1964.
John Henry Karsten, Dodge County, July 28, 1964.
Dorothy Mendenhall, nonmember, July 31, 1964.
Theodore N. Joyner, nonmember, August 2, 1964.
Paul John Dailey, Langlade County, August 5, 1964.
Sidney H. Wetzler, Milwaukee County, August 5, 1964.
Thomas S. Burdon, Brown County, August 6, 1964.
William A. Werrell, Dane County, August 14, 1964.
Jesse W. Shaw, Manitowoc County, August 25, 1964.
Frank H. Kennedy, Jefferson County, August 29, 1964.
Arnold S. Jackson, Dane County, August 30, 1964.
William A. Langmack, Columbia-Marquette-Adams County, August, 1964.

WISCONSIN LICENTIATES

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Madison, January 14, 15, 16, 1964.

Name	*School of Graduation*	*Year*	*City*
Allen, Maurey Lee, II	University of Wisconsin	1963	Madison
Beck, James Paul	University of Wisconsin	1963	Milwaukee
Bergom, Ronald O.	University of Wisconsin	1963	Grand Forks, N. D.
Bernhardt, Louis C.	University of Wisconsin	1963	Madison
Bronson, Fredrick H.	University of Wisconsin	1963	Portage
Brown, Dwight H.	Marquette University	1963	Milwaukee
Brunette, Kenneth W.	University of Wisconsin	1962	Madison
Curran, James D.	University of Ireland	1955	Milwaukee
Dimitrov, Nikolay V.	Academy of Medicine	1951	Cleveland, Ohio
Finstad, James E.	University of Wisconsin	1962	Minneapolis, Minn.
Frechette, Paul Francis	University of Wisconsin	1962	Madison
Froelich, Ralph D.	University of Wisconsin	1963	Johnson Creek
Gilmore, Mark A.	University of Wisconsin	1963	Highland Park, Ill.
Golbert, Thomas M.	University of Colorado	1962	Milwaukee
Juel, Eugene P.	University of Wisconsin	1963	Miami Shores, Fla.
Jungjohann, Eugen E.	University of Cologne	1957	Madison
Kamstra, Egbert	State University	1954	Monroe
Koenig, Erwin F.	Marquette University	1960	Madison
Kulczycki, Barbara A.	Marquette University	1962	Milwaukee
Luck, Allan	University of Wisconsin	1963	Milwaukee
Luck, Bernard	University of Wisconsin	1963	Milwaukee
Manz, Carl W.	University of Wisconsin	1963	Eau Claire
Marks, Charles	University of Cape Town	1945	Milwaukee
Mathison, David August	University of Wisconsin	1963	Rochester, N. Y.
Melkonian, Abdallah G.	Ein Shams University Abbassiah Faculty of Medicine	1955	Milwaukee
Reeb, Kenneth G.	University of Wisconsin	1963	Minneapolis, Minn.
Ripple, Harold L.	Marquette University	1960	Milwaukee
Rodgers, Richard E.	University of Chicago	1962	Milwaukee
Slocumb, Charles O.	University of Wisconsin	1963	Twin Lakes
Strebel, Ronald L.	University of Wisconsin	1963	Green Bay
Sun, Kwoh Cheng	Tung Nan Medical College	1944	Siren
Taitelbaum, Ben	University of Wisconsin	1962	Milwaukee
Thranow, John A., Jr.	University of Wisconsin	1963	La Crosse
Traver, Myrna	University of Wisconsin	1962	Madison
VonGradulewski, Margaret	University of Berlin	1935	Necedah
Wax, Robert	University of Wisconsin	1963	San Francisco, Cal.
Wesenberg, Richard L.	University of Wisconsin	1962	Madison

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 17, 1964.

Name	*School of Graduation*	*Year*	*City*
Angell, David C.	McGill Univ.	1955	Eau Claire
Bedford, Fred G.	U. of Minnesota	1956	Oconomowoc
Benfield, John R.	U. of Chicago	1955	Chicago, Ill.
Bergmann, Franklyn T.	U. of Wisconsin	1960	Shawano
Bourne, Richard B.	U. of Michigan	1958	Milwaukee
Breyer, Julius P.	Pazmany Peter Univ.	1926	Union Grove
Chambers, William	U. of Cincinnati	1933	Cincinnati, Ohio
Coffey, Brian T.	Marquette Univ.	1960	Racine
Collins, Daniel P.	Loyola Univ.	1957	West Allis
Emerson, Edward C.	U. of Minnesota	1925	St. Paul, Minn.
Gerner, Robert E.	U. of Texas	1958	Milwaukee
Helling, R. David	Marquette Univ.	1962	Milwaukee
Hildebrand, Fredric	U. of Pennsylvania	1960	Menasha
Hill, John P.	Northwestern Univ.	1952	Harvard, Ill.
Leagus, Charles J., Jr.	Hahnemann Med. Col.	1957	Milwaukee
Litofsky, Arthur	U. of Maryland	1958	Milwaukee
Logan, Richard	U. of Illinois	1958	Madison
Moore, Bernard J.	Marquette Univ.	1953	Arlington Hts., Ill.
Nathan, Lester A.	U. of Chicago	1953	Skokie, Ill.
Nienhuis, Herman D.	U. of Michigan	1958	Janesville
Papadakes, Nicholas	U. of Iowa	1960	Milwaukee
Popp, Mark J.	Marquette Univ.	1963	Rantoul, Ill.
Potter, George L.	McGill Univ.	1955	Neenah
Schmid, John F.	U. of Minnesota	1942	Duluth, Minn.
Schmidt, Donald H.	U. of Wisconsin	1960	Eagle River
Sellers, Robert L.	U. of Illinois	1961	N. Syracuse, N. Y.
Sinclair, Eugene P.	Marquette Univ.	1961	Ft. Campbell, Ky.
Smith, Clifford C., Jr.	Meharry Med. Col.	1953	McGregor, Iowa
Sundstrom, Walter R.	Loyola Univ.	1957	Madison
Wang, Richard I. H.	Northwestern Univ.	1955	Milwaukee
Wind, Joseph L.	State Univ. of N. Y. Downstate Medical Center, New York	1957	West Allis
Zarbock, Floyd M.	U. of Texas	1963	Mukwonago

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 14, 15, 16, 1964.

Name	*School of Graduation*	*Year*	*City*
Arik, Mehmet	University of Istanbul	1946	Louisville, Ky.
Azcueta, Ester S.	University of Santo Tomas	1952	Milwaukee
Cantwell, Arthur A., Jr.	Northwestern University	1961	Riverside, Cal.
Churchill, Don Warren	University of Wisconsin	1957	Indianapolis, Ind.
Galos, Katherine J.	University of Wisconsin	1963	Madison
Goodsitt, Alan	University of Wisconsin	1963	Milwaukee
Hahn, Michael F.	University of Wisconsin	1963	Madison
Hutter, Adolph M., Jr.	University of Wisconsin	1963	Rockville, Md.
Kohlberg, Irving J.	University of Wisconsin	1963	Milwaukee
Koschmann, Edgar B.	University of Wisconsin	1963	Milwaukee
Lelonek, Robert D.	Creighton University	1961	Milwaukee
Martinez-Larre, Marcial	University of Santo Domingo	1932	Racine
Meisels, Alfred	University of Vienna	1958	Milwaukee
Molot, Mark D.	University of Ottawa	1962	Milwaukee
Pinell, Octavio (Midence)	National University of Nicaragua	1956	Rochester, Minn.
Rivera, Fernando, Jr.	University of Santo Tomas	1953	Steubenville, O.
Ruiz, Dionicio L.	University of Wisconsin	1963	Hamilton AFB, Cal.
Schumacher, Robert V.	University of Wisconsin	1963	Holmen
Shafer, James S.	University of Wisconsin	1963	Schofield
Villacrez, Jose A.	University of San Marcos	1958	Monroe

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 15, 1964.

Name	*School of Graduation*	*Year*	*City*
Allen, William	Ohio State University	1957	Wisconsin Rapids
Bachhuber, Michael W.	Marquette University	1963	Mayville
Berk, Dennis P.	Cornell University	1963	Madison
Borsuk, Gregory M.	Seton Hall College of Med.	1962	Milwaukee
Briggs, Russell C.	Albany Medical College	1958	Madison
Buerger, Edward J.	Marquette University	1963	Milwaukee
Burg, Edward A., Jr.	Temple University	1960	Wauwatosa
Carpenter, William	University of Alberta	1956	St. Paul, Minn.
Chadbourn, John A.	Marquette University	1963	Columbus
Chicks, Sheldon A.	Marquette University	1963	Milwaukee

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
Chu, Shun Wu	Nat.Defense Med. Center	1945	Broadview, Ill.
Cohan, Richard C.	New York University	1963	Madison
Cohill, Donald F.	University of Pennsylvania	1960	Shawano
Congress, Mark I.	Georgetown University	1963	Milwaukee
Connally, Joseph M., Jr.	University of Texas	1961	Madison
Crago, Rex M.	University of Illinois	1961	Wauwatosa
Datka, Gordon L.	Marquette University	1963	Wauwatosa
Dicus, William T.	Northwestern University	1963	Evanston, Ill.
Donaldson, Robert M., Jr.	Boston University	1952	Madison
Dortzbach, Richard K.	University of Pennsylvania	1963	Madison
Dyson, Burton C.	University of Pennsylvania	1946	Wausau
Epstein, Murray	Columbia University	1963	Madison
Eyer, Simon W.	Northwestern University	1940	Madison
Fine, Stuart W.	University of Louisville	1963	Milwaukee
Fisk, Norman M.	University of Tennessee	1959	Milwaukee
Fortier, George M. A.	Marquette University	1963	Milwaukee
Foster, Lawrence L.	Marquette University	1963	Milwaukee
Fredericks, Edward J.	Cornell University	1962	Madison
Garman, James E.	University of Iowa	1955	Milwaukee
Genna, Mary Miller	Indiana University	1947	Hales Corners
Goldstein, Paul H.	University of Illinois	1960	Chicago, Ill.
Grabow, Jack D.	University of Buffalo	1956	Madison
Gunn, Walter G.	Stanford University	1955	Wauwatosa
Gutmann, Frank D.	State University of N. Y.	1963	Madison
Holland, Cleon R.	Hahnemann Medical College	1940	Rochester, Minn.
Holt, Marsh H.	Northwestern University	1960	Milwaukee
Holtey, Warren J.	Johns Hopkins University	1959	Marshfield
Illberg, Peter	University of Zurich	1961	Helmuth, N. Y.
Jachowicz, Robert B.	Marquette University	1963	Milwaukee
Johnson, Daniel F.	Washington University	1961	Madison
Johnson, Robert Lee	University of Minnesota	1960	Madison
Kessler, Richard A.	Marquette University	1963	Rantoul, Ill.
Klink, Douglas D.	University of Iowa	1956	Milwaukee
Kortebein, Stuart R.	Loyola University	1957	Glencoe, Ill.
Kowalski, Thomas H.	Marquette University	1963	Milwaukee
Kundel, Robert R.	University of Iowa	1956	Rice Lake
Larson, Lawrence S.	Marquette University	1963	Pt. Washington
Lemmons, Ronald E.	Tulane University	1958	Manitowoc
Limoni, Patrick F.	Marquette University	1963	Milwaukee
Ludwig, Arnold M.	University of Pennsylvania	1958	Madison
Lustig, Karl A.	Seton Hall	1963	New Berlin
Marschke, Gerald R.	University of Minnesota	1955	Marshfield
Maryland, Daniel L.	University of Minnesota	1959	Duluth, Minn.
McIntyre, Donald R.	University of Pennsylvania	1963	Madison
McMaster, John D.	Temple University	1951	Madison
Merulla, Charles A.	University of Iowa	1957	Madison
Meyer, Anthony D.	Marquette University	1963	Pewaukee
Milburn, William H.	University of California	1963	Madison
Miner, Edward B.	University of Wisconsin	1957	La Crosse
Myalls, Walter	Loyola University	1959	Oak Park, Ill.
Myers, Maurice E.	Marquette University	1963	Durand
Nadler, Henry L.	Northwestern University	1961	Madison
Nighswander, John R.	University of Illinois	1961	Wauwatosa
Onkst, Harold R.	Ohio State University	1954	Brookfield
Owen, Nicholas L.	Washington University	1959	Milwaukee
Pandazi, Andrew A.	Marquette University	1963	Milwaukee
Propeck, Stephen L.	Northwestern University	1963	Wauwatosa
Pyle, Richard L.	University of Colorado	1958	Waupun
Rossman, Lawrence J.	Marquette University	1961	Wauwatosa
Roth, S. Burton	Chicago Medical School	1963	Whitefish Bay
Sambs, James M.	Marquette University	1963	West Allis
Sett, Ralph F.	Marquette University	1963	Milwaukee
Short, Howard W.	University of Cincinnati	1961	Wauwatosa
Siegert, Robert F.	University of Illinois	1963	Wauwatosa
Stecker, Raymond H.	University of Wisconsin	1958	Rochester, Minn.
Theis, E. Howard	University of Illinois	1960	St. Louis, Mo.
Till, Eugene W.	Marquette University	1963	Cudahy
Tope, John W.	Northwestern University	1947	Oak Park, Ill.
Unterholzner, Warren	Marquette University	1963	Milwaukee
Walker, Thomas F.	Marquette University	1963	Milwaukee
Wegner, Kenneth J.	University of Michigan	1963	Milwaukee
Wilson, Eric B.	University of Illinois	1963	Carrollton, Ill.
Zalar, Joseph A., Jr.	University of Illinois	1963	Milwaukee
Zinn, Charles J.	University of Pennsylvania	1927	Wisconsin Dells

1964 **Wisconsin**

Dec. 15: Milwaukee Academy of Medicine, University Club, Milwaukee.

1965

Jan. 23–24: Triological Society, Wisconsin Center, Madison.

Jan. 28: U. W. "In Depth" program—Surgery: "Colon and Rectal Surgery in Children and Adults"—at University Hospitals and State Medical Society, Madison.

Feb. 5–8: Wisconsin Psychiatric Association, annual scientific meeting, Coach House Motor Inn, Milwaukee.

Feb. 17: U. W. "In Depth" program—Orthopedics: "Congenital Hips and Foot Deformities in Children" —at University Hospitals and State Medical Society, Madison.

Mar. 18: U. W. "In Depth" program—Obstetrics and Gynecology· "Endocrine Problems in Gynecology"—at University Hospitals and State Medical Society, Madison.

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

May 15: Wisconsin Heart Association, 17th annual meeting and scientific sessions, Coach House Motor Inn, Milwaukee.

June: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

1964 **Out-of-State**

Dec. 1–3: 15th annual Veterans Administration research conference, Netherland Hilton Hotel, Cincinnati, O.

Dec. 5–10: American Academy of Dermatology, 23rd annual meeting, Palmer House, Chicago, Ill.

Dec. 11–12: American Medical Association, conference on blood and blood banking, Drake Hotel, Chicago, Ill.

Dec. 11–12: American College of Physicians, New Mexico regional meeting, White Winrock Hotel, Albuquerque, N.M.

Dec. 14–16: Postgraduate Assembly in Anesthesiology, New York State Society of Anesthesiologists, Hilton Hotel, New York City.

1965

Jan. 4–8: American College of Physicians, postgraduate course No. 6, stroke and the cerebrovascular diseases, Rancho Los Amigos Hospital, Downey, Calif.

Jan. 9–10: 2nd annual symposium for physicians, cosponsored by American Therapeutic Society and Minnesota Heart Association, Radisson Hotel, Minneapolis, Minn.

Jan. 14–16: Postgraduate course in Dermatology in General Practice, sponsored by the Mound Park Hospital Foundation, 701 Sixth Street, South, St. Petersburg, Fla. 33701.

Jan. 17–23: University of Colorado School of Medicine, 11th annual general practice review, Denver.

Jan. 20–22: American Diabetes Association, in cooperation with Diabetes Association of Greater Chicago, 12th postgraduate course, "Diabetes in Review: Clinical Conference," Drake Hotel, Chicago.

Jan. 22–Feb. 4: International College of Surgeons, Caribbean surgical congress, aboard the S. S. Santa Paula, La Guaira, Curacao, Aruba, and Kingston.

Jan. 25–28: 24th research conference in pulmonary diseases of Veterans Administration–Armed Forces (formerly conference on chemotherapy of tuberculosis), LaSalle Hotel, Chicago, Ill.

Jan. 25–30: Workshop in Teratology, University of California, Berkeley.

Feb. 1–5: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, Hotel Fontainebleau, Miami Beach, Fla.

Feb. 10–13: American College of Radiology, Philadelphia, Pa.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Feb. 15–17: American College of Surgeons, sectional meeting, Bellevue–Stratford Hotel, Philadelphia, Pa.

Feb. 15–18: Medical Society of the State of New York, 159th annual convention, The Americana, New York City.

Feb. 15–19: American College of Physicians, postgraduate course No. 7, pathology, pathologic physiology, and clinical aspects of renal disease, Presbyterian–St. Luke's Hospital, Chicago, Ill.

Feb. 20–23: University of Utah College of Medicine, annual postgraduate course in anesthesiology, Salt Lake City.

Feb. 22–26: American College of Physicians, postgraduate course No. 8, pain and addiction, Massachusetts General Hospital, Boston, Mass.

Mar. 13–18: International Academy of Proctology, 17th annual teaching seminar, Jung Hotel, New Orleans, La.

March 15–20: University of Colorado School of Medicine, 6th postgraduate course in medical technology.

Mar. 28–Apr. 1: International Anesthesia Research Society, 39th congress, Washington, D. C.

Mar. 29–Apr. 10: Postgraduate course in laryngology and bronchoesophagology given by Department of Otolaryngology, College of Medicine of University of Illinois, at Illinois Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill.

Apr. 5–8: American College of Obstetricians and Gynecologists, annual clinical meeting, San Francisco, Calif. Postgraduate courses, Apr. 3–4.

Apr. 5–8: American industrial health conference, sponsored by Industrial Medical Association and American Association of Industrial Nurses, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 12–16: American College of Obstetricians and Gynecologists, Section of Hawaii, "Meeting on Maui."

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: American Medical Association, Section on Radiology, New York City.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

1966

Sept. 20–28: 10th Congress of Pan-Pacific Surgical Association, Part I, Princess Kaiulani Hotel, Honolulu, Hawaii.

Sept. 26–30: Third International Congress of Nephrology, sponsored by American Heart Association and International Society of Nephrology, Washington, D.C.

Sept. 28–Oct. 10: 10th Congress of Pan-Pacific Surgical Association, Part II, Second Mobile Educational Seminar, Japan and Hong Kong.

Sept. 28–Nov. 1: Part III, Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia, and New Zealand.

Oct. 10–14: American College of Surgeons, annual clinical congress, San Francisco, Calif.

ACP Postgraduate Course at Chicago

The American College of Physicians will conduct its Postgraduate Course No. 7 Feb. 15–19, 1965, at Presbyterian-St. Luke's Hospital, Chicago, Ill., with Dr. Robert M. Kark, F.A.C.P., as director. "Pathology, Pathologic Physiology, and Clinical Aspects of Renal Disease" will be featured. The program is divided into symposia on renal problems of current clinical interest followed by panel discussions dealing with practical aspects of treatment. The immediate problems of patients will be discussed at radiology conferences and at pediatric, surgical, and medical grand rounds.

The faculty includes basic scientists and clinicians from Great Britain, Canada, and the United States who will augment the staff from the University of Illinois.

Registration forms and requests for information may be directed to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Course on Pain and Addiction

The American College of Physicians Postgraduate Course No. 8, "Pain and Addiction," will be given Feb. 22–26, 1965, at Massachusetts General Hospital, sponsored by Harvard Medical School, Boston, Mass.

Frequency and gravity of pain as a clinical problem in medicine will be presented, followed by a systematic review of the known facts concerning the anatomy and physiology of pain and the presentation by seasoned clinicians of the types of pain problems encountered in medicine, surgery, and psychiatry and their subspecialties. The final section will be devoted to the management of the pain problem, with the problem of drug addiction and experiences with the management of this condition concluding the course.

Registration forms and requests for information should be addressed to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Academy of Proctology Seminar

The International Academy of Proctology will present its 17th annual teaching seminar at the Jung Hotel, New Orleans, La., Mar. 13 through 18, 1965. Eminent teachers from all parts of the world will lecture on office proctology, psychosomatic aspects of proctology, colon surgery, medical proctology, and nuclear medicine in proctology. Major teaching films in the field will be shown, each to be followed by an individual or panel discussion.

The International Board of Proctology will present diplomate certificates at a convocation following the last day of the meeting.

Industrial Health Conference

The 1965 American Industrial Health Conference will be held April 5–8 at the Americana Hotel, Bal Harbour, Miami Beach, Fla., the Industrial Medical Association and the American Association of Industrial Nurses have announced. This medical-nursing conference is comprised of the annual meetings of the two sponsoring associations. Many of the nation's experts in the field of occupational health will participate in the scientific program, which will be augmented by both scientific and technical exhibits. Intensive courses in selected areas of medical practice will also be presented.

Further information may be obtained by writing American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

WHA Annual Meeting

Wisconsin Heart Association's 17th annual meeting and scientific sessions have been slated for May 15, 1965, at the Coach House Motor Inn, Milwaukee. Programs for the physicians' scientific sessions, nurses, and lay members are being planned.

Academy of Physical Medicine, Rehabilitation

The annual meeting of the American Academy of Physical Medicine and Rehabilitation will be held Aug. 22–27, 1965, at the Sheraton Hotel, Philadelphia, Pa. It will consist of formal lectures, as well as educational seminars in the field of hypertonia, hypotonia, and forensic physiatry (workmen's compensation).

APA Area 4 Meeting

The Area 4 meeting of the American Psychiatric Association is scheduled for Oct. 8–10, 1965, in St. Louis, Mo. Individuals proposing a paper for the meeting should write to Paul A. Dewald, M.D., 4524 Forest Park Blvd., St. Louis, Mo. 63108. Those who are planning exhibits are asked to write to Thomas Thale, M.D., 4511 Forest Park Blvd., St. Louis, Mo. 63108.

SMA Ophthalmology Section

The Section of Ophthalmology of the Southern Medical Association announces that papers are now being accepted for consideration for presentation at the next annual meeting, Nov. 1–4, 1965, in Houston, Tex. Papers with a short abstract and the exact title should be sent at once and up to May 15, 1965, to the Secretary, Dr. George E. Ellis, 812 Maison Blanche Bldg., New Orleans, La. 70116.

Dermatologists' Annual Meeting

The American Academy of Dermatology will hold its 23rd annual meeting December 5–10 at the Palmer House, Chicago.

More than 1,300 dermatologists and other physicians are expected to attend the six-day meeting, which will include scientific presentations on new developments in skin disease and dermatology re-

search. Symposia on major skin problems and special guest lectures will complete the program.

General Practice Review at Denver

The University of Colorado School of Medicine announces the 11th annual general practice review Jan. 17–23, 1965, at Denver, Colo. The program for this annual postgraduate course designed especially for the general practitioner is as follows: Sunday, Medical Aspects of Marriage and Family Living; Monday, Medicine; Tuesday, Pediatrics; Wednesday, Surgery; Thursday, Urology; Friday, Obstetrics and Gynecology; Saturday, Dermatology.

Further information and the detailed program may be obtained by writing to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver, Colo. 80220.

Surgery Program at UW

Colon and rectal surgery will be featured at the University of Wisconsin Medical School's third "In-Depth" one-day teaching program on Thursday, Jan. 28, 1965.

Dr. Robert Turell of New York City will be the visiting faculty. UW faculty will include Drs. Frank Weston, Sture A. M. Johnson, Robert Hickey, Kenneth Lemmer, Robert Samp, and J. Benfield. Plans are being made for actual operations at University Hospitals, 1300 University Avenue, Madison (if proper material is available) with viewing in Room 300 via closed circuit TV. Subjects will include anorectal disease, diseases of the perianal area, anal fissure, fistula, hemorrhoids, prolapse, polyps, ulcerative colitis, diverticulosis, diverticulitis, and practical aspects of colostomy and ileostomy care.

Again, a "wet clinic" will be held at 10 a.m. in Room 300. Lunch at 12:30 and the lecture program at 1:15 p.m. will take place at the State Medical Society building, 330 East Lakeside St., Madison.

Full details may be obtained by writing Roy T. Ragatz, State Medical Society, Box 1109, Madison, Wis.

WPA Annual Scientific Meeting

The annual scientific meeting of the Wisconsin Psychiatric Association will take place Feb. 5 and 6, 1965, at the Coach House Motor Inn, Milwaukee. Subject will be "The Psychotherapeutic Process and/or the Educational Process." A full program is being planned by Dr. Ervin Teplin, Milwaukee, and his committee: Drs. Paul G. Stein and Jack Geist, Milwaukee; Martin B. Fliegel and Leigh M. Roberts, Madison; and James F. Caffrey, Green Bay.

ACS Sectional Meeting

The American College of Surgeons will hold the second of three 1965 sectional meetings Feb. 15–17 in Philadelphia, Pa. More than a thousand surgeons are expected to attend the three-day program at the Bellevue-Stratford Hotel.

It will include sessions in the specialties of orthopedic surgery, proctology and neurosurgery as well as general surgery. Among topics of discussion; organ transplantation, common duct reconstruction, skin grafting, peptic ulcer, thrombophlebitis, problems of the cervical spine, unusual and commonplace metabolic bone diseases in children and adults, management of anorectal infections, rectal polyps, ulcerative colitis, painful phantom limb; a new surgical approach, the problem of recurrent low back and sciatic pain following primary operation for lumbar disc protrusion.

Official hotel housing forms may be obtained from: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

Triological Society Meeting

The Middle Section meeting of the American Laryngological, Rhinological and Otological Society ("The Triological Society") is slated for January 23–24, 1965, at The Wisconsin Center, Madison. Cooperating in the meeting are the University of Wisconsin Medical Center and Extension Division.

Guided tours of University Hospitals, 1300 University Avenue, are scheduled from 8 to 10 a.m. January 23, followed by Grand Rounds in Room 227 of the S.M.I. Auditorium. Appearing by invitation will be Dr. John K. Scott, assistant clinical professor of surgery (otolaryngology) at the University of Wisconsin. Slated are a report and review of 16 cases of advanced diabetic retinopathy for which transphenoid hypophysectomy has been performed. Also appearing by invitation will be Dr. Robert O. Johnson, assistant professor of surgery (Division of Clinical Oncology) at the University, "Newer Chemotherapeutic Agents for Advanced Head and Neck Cancer."

Registration will take place at 11 a.m. at The Wisconsin Center. Presiding at the afternoon session at the Auditorium will be Dr. Meyer S. Fox, Milwaukee, vice-president of the Middle Section. He will introduce the Society president, Dr. George E. Shambaugh, Jr., Chicago.

Papers presented will include: "Vestibular and Cochlear Aqueducts: Their Variational Anatomy in the Adult Temporal Bone;" "Immediate Glottic Function Restoration after Thoracic Surgery;" "Other Forms of Face Pain," (presented by Dr. J. D. Kabler, Madison); "Experimental Observations upon Reconstruction of the Nasal Dorsum;" and "Otitic Temporal Lobe Abscesses."

Papers presented at the January 24 meetings will be on the subjects: "Trismus;" "Clinical and X-Ray Diagnosis of Labyrithine Otosclerosis;" "A Histological and Experimental Study of Coachlear Aqueduct Patency i nthe Adult Human;" "What Happens with Type III Tympanoplasty?" and "Some New Evidence on the Pathogenesis of Otosclerosis."

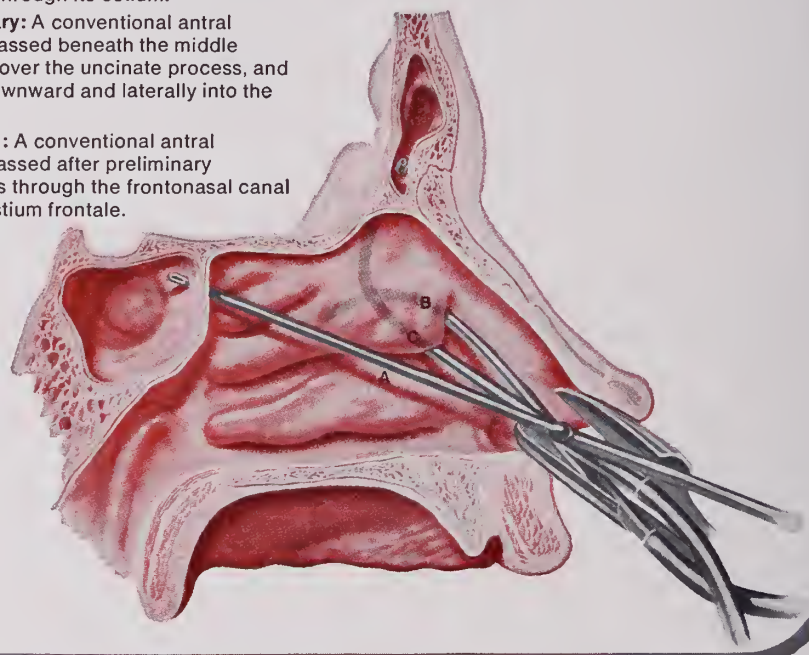
Program coordinator for the meeting is Dr. Maxine Bennett, Madison, associate professor of surgery at the University.

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



In colds and sinusitis

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can help prevent emergency measures later

Before complications arise in colds and sinusitis, Neo-Synephrine solutions and sprays reduce nasal turgescence on contact – to promote essential aeration and drainage. Turbinates shrink, sinus ostia open and drainage is freed. Relief is instant and the threat of complications is lessened.

In the treatment of sinusitis, the ¼ per cent solution is a preferred vasoconstrictor, "...most closely approximating physiologic composition with the least 'rebound' tendency...."* Gentle Neo-Synephrine is well tolerated by delicate respiratory tissues. Systemic effects are practically nil, post-therapeutic turgescence is minimal and repeated applications do not lessen its effectiveness. Neo-Synephrine has been a standard among vasoconstrictors since 1935.

Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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New York, N. Y.

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BOOKS RECEIVED

HANDBOOK OF PEDIATRICS

By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. 5th edition. Lange Medical Publications, Los Altos, Calif. 1963. 208 pages. Price: $4.00.

SYNOPSIS OF PEDIATRICS

By James G. Hughes, B.A., M.D., Professor of Pediatrics and Chairman of the Department of Pediatrics, University of Tennessee College of Medicine, Memphis, Tenn. C. V. Mosby Co., St. Louis, Mo. 1963. 1031 pages. Price: $9.85.

HANDBOOK OF ORTHOPAEDIC SURGERY

By Alfred Rives Shands, Jr., B.A., M.D., F.A.C.S., Richard Beverly Raney, B.A., M.D., F.A.C.S., H. Robert Brashear, B.A., M.D., F.A.C.S. 6th edition. C. V. Mosby Co. St. Louis, Mo. 1963. 591 pages. Price: $11.50.

PHYSICAL DIAGNOSIS

The History and Examination of the Patient. By John A. Prior, M.D., Professor of Medicine and Associate Dean, and Jack S. Silberstein, M.D., Clinical Associate Professor of Medicine, Ohio State University College of Medicine, Columbus, O. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 455 pages. Price: $8.50.

ADVANCES IN RHEUMATIC FEVER 1940–1961

By May G. Wilson, M.D., Professor of Clinical Pediatrics, Emeritus, Cornell University Medical College; Consulting Pediatrician and Director, Rheumatic Fever Research, The New York Hospital, New York, N. Y. Hoeber Medical Division, Harper and Row, Publishers, New York, N. Y. 1962. 249 pages. Price: $10.00.

BRAY'S CLINICAL LABORATORY METHODS

Revised by John D. Bauer, M.D., Gelson Toro, Ph.D., and Philip G. Ackermann, Ph.D. 6th edition. C. V. Mosby Co., St. Louis, Mo. 1962. 594 pages. Price: $10.50.

THE ABDOMINAL COMPRESSION REACTION

Activity of Abdominal Muscles Elicited from the Circulatory System. By W. B. Youmans, M.D., Ph.D., Q. R. Murphy, M.D., Ph.D., J. K. Turner, Ph.D., L. D. Davis, Ph.D., D. I. Briggs, Ph.D., A. S. Hoye, Ph.D., Department of Physiology, University of Wisconsin Medical School, Madison, Wis. The Williams & Wilkins Co., Baltimore. 1963. 70 pages. Price: $4.00.

THE EXOCRINE PANCREAS

Normal and Abnormal Functions. Ciba Foundation Symposium. Edited by A. V. S. de Reuck, M. Sc., D. I. C., A. R. C. S., and Margaret P. Cameron, M. A. Little, Brown and Co., Boston. 390 pages. Price: $11.50.

ACCIDENT SURGERY

Edited by H. Fred Moseley, M.A., D.M., M.Ch., F.R.C.S., F.A.C.S., Director of Accident Service and Surgeon, Royal Victoria Hospital; Associate Professor of Surgery, McGill University, Montreal; Hunterian Professor, Royal College of Surgeons of England. Appleton-Century-Crofts, New York, N. Y. 1962. 242 pages. Price: $10.00.

PULMONARY STRUCTURE AND FUNCTION

Ciba Foundation Symposium. Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A. Little, Brown and Co., Boston. 1962. 403 pages. Price: $11.50.

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES

By Adolph G. DeSanctis, M.D., and Charles Varga, M.D. 3rd edition. C. V. Mosby Co., St. Louis, Mo. 1963. 457 pages. Price: $12.75.

IMMUNOASSAY OF HORMONES

Ciba Foundation Colloquia on Endocrinology. Volume 14. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. Little, Brown and Co., Boston. 1962. 419 pages. Price: $10.75.

BOOK REVIEWS

EMOTIONAL FACTORS IN PUBLIC HEALTH NURSING

A Casebook. Ed. by Abraham B. Abramovitz, for the Wisconsin State Board of Health. University of Wisconsin Press, Madison, 1961. 171 pages. Price: $4.00.

Nine case situations used with public health nurses in an inservice education program comprise the major part of the content of this book. Introductory and concluding chapters written by Louis H. Orzack, Associate Professor, Department of Sociology and Anthropology, Boston University, are useful in highlighting general concepts and some issues that stem from the material presented in the case studies.

The author hopes to assist nurses and others in helping professions "to become more aware of the common feelings and needs of all human beings." The case studies, which relate mainly to problems of school-age children and adults under 45 years of age, should help the reader do this. References and discussion aids listed at the end of each chapter can be most useful to individuals and groups. Some of the questions raised at the end of the chapters can be helpful also. However, the long lists of questions seem to go beyond the implications of the material.

The case studies highlight the broad scope of problems within families that cannot be separated from a referral of one family member to a public health nurse. The author believes that the content of this book can help nurses increase their self-understanding as well as understanding of the behavior of the patients and families with whom they work. *Emotional Factors in Public Health* is a worthwhile reference for use in undergraduate courses in nursing and in inservice education programs for nurses.—LOUISE C. SMITH, Ed.D. and R.N.

The State Medical Society of Wisconsin

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Delegates to American Medical Association
(Terms end on December 31 of year indicated)

John M. Bell, Marinette, 1966
E. L. Bernhart, Milwaukee, 1966
R. E. Galasinski, Milwaukee, 1965
A. A. Quisling, Madison, 1965

Alternates

J. C. Fox, La Crosse, 1966
C. J. Picard, Superior, 1966
George Collentine, Jr., Milwaukee, 1965
W. B. Hildebrand, Menasha, 1965

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	L. W. Moody Bayfield	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	H. O. Jirsa Cumberland	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	L. H. Edelhlute 744 S. Webster Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	John A. Knauf Stockbridge	
Chippewa	Charles A. Kemper 727 Maple, Chippewa Falls	James L. Windeck 600 Bay St., Chippewa Falls	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wedoesday
Dane	Robert A. Straughn 30 S. Henry, Madison	J. H. Morledge 30 S. Henry, Madison	Second Tuesday**
Dodge	Norman Erickson 302 N. Spring St., Beaver Dam	N. H. Schulz 317 E. Lake St., Horicon	Last Thursday*
Door–Kewaunee	W. S. Hobson 25 S. Madison, Sturgeon Bay	David Papendick 801 Fourth St., Algoma	
Douglas	Thomas J Doyle 1507 Tower Ave., Superior	Oscar Farias Hawthorne	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Mooday
Fond du Lac	Harold Kief 104 So. Main St. Fond du Lac	W. G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	Carol E. Mueller Boscobel	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	John M. Irvin 2101 6th St., Monroe	Frank C. Stiles 921 16th Ave., Monroe	
Green Lake–Waushara	Russell C. Daroy Wautoma	Roy Hong Wild Rose	Last Thursday, every other month starting in Jan.

* Except June, July aod August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	E. J. Hohler Mineral Point	H. P. Breier Montfort	First Thursday following first Monday
Jefferson	J. J. Harris 311 N. Main, Ft. Atkinson	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	C. A. Sattler 6401 Sheridan Rd., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	Frederick H. Wolf 419 Main St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	L. J. Unterholzner Box 115, Blanchardville	L. L. Olson 504 Wells St., Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	Earl J. Roth 606 Superior, Antigo	First Monday
Lincoln	William Braun 412 W. Main St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	Charles E. Wall 904 South 8th St. Manitowoc	G. H. Stannard, Jr. 1425 Grinnell Lane Manitowoc	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	Charles Koepp 516 Houston St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Robert S. Haukohl 620 N. 19th St., Milwaukee	Donald P. Babbitt 1700 W. Wisconsin Avenue Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	Michael Barton 907 Main St., Oconto	
Oneida–Vilas	George F. Pratt 617 Lake Shore, Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	Ralph S. Gage 314 Kimberly Ave. Kimberly	John H. Russell 103 W. College Ave., Appleton	Third Thursday* Elks Club
Ozaukee	Kenneth F. Pelant 1240 13th Ave., Grafton	Allen Misch 204 N. Washington St., Cedarburg	
Pierce–St. Croix	Ernest Drury New Richmond	P. H. Gutzler River Falls	Third Tuesday
Polk	Leo Nelson St. Croix Falls	John O. Simenstad Osceola	Third Thursday 7:00 p.m.
Portage	R. H. Slater 401 Main St., Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	Frank J. Scheible 632 High St., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	George Parke, Jr. 323 So. Central Ave., Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	E. W. Remardy 2020 Milw. Ave., Janesville	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	I. A. Galarnyk Plain	Gibbs W Zauft 590 4th St., Prairie du Sac	Second Tuesday*
Shawano	H. F. Laufenburg Shawano	A. J. Sebesta 126½ S. Main St., Shawano	Third Wednesday
Sheboygan	Donald M. Rowe Kohler	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Albert Daniells 903 Filmore St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Joseph Syty Viroqua	C. A. Ender 120 W. Court St., Viroqua	Last Wednesday
Walworth	Henry F. Bischof 845 Main St., Lake Geneva	Rocco S. Galgano 610 Walworth, Delavan	Second Thursday*
Washington	James Albrecht 118 E. Main St., Jackson	W. E. Scheunemann 626 Cedar St., West Bend	Fourth Thursday
Waukesha	Robert Monk 217 Wis. Bldg., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	Kenneth L. Haman Waupaca	Lloyd P. Maasch Weyauwega	
Winnebago	R. V. Kuhn 219 West 9th St., Oshkosh	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	George H Handy 441 Mead Circle Wisconsin Rapids	John W. Rupel 630 S. Central, Marshfield	Four times a year

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL, Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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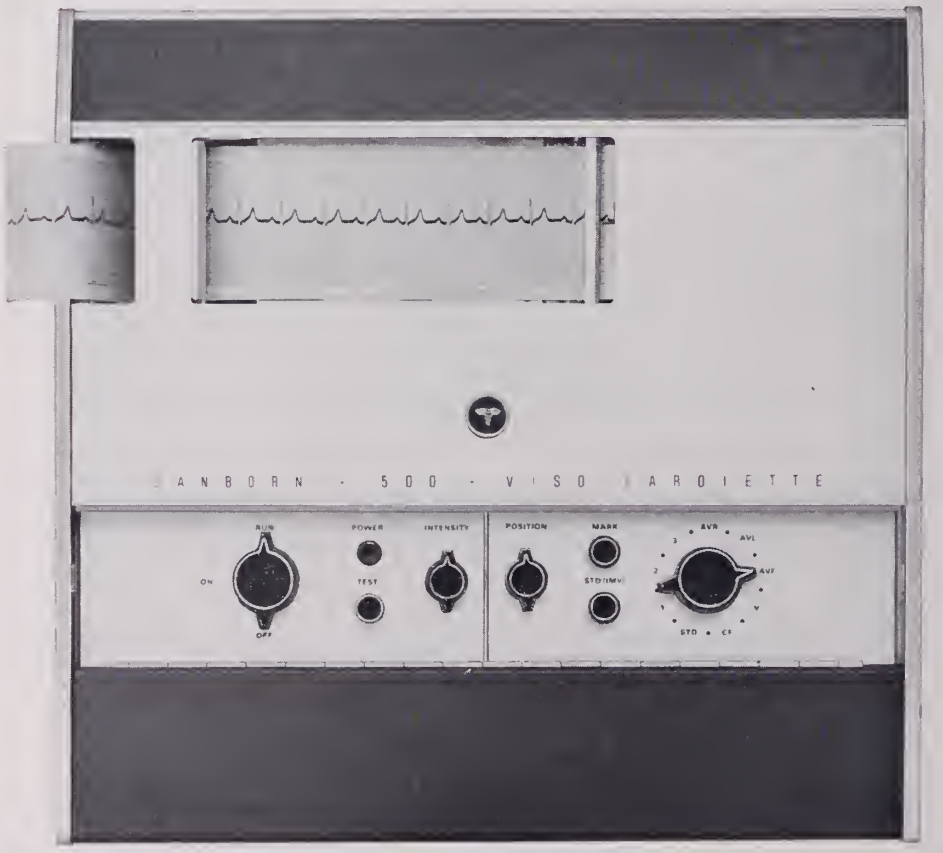

MILWAUKEE *Resident Representative* 743 No. Fourth Street, Broadway 1-3883

COUNTY SOCIETY PROCEEDINGS

BROWN

Approximately 45 physicians attended the November 12 meeting of the Brown County Medical Society at the Northland Hotel, Green Bay. Following dinner, they heard a discussion of the Bobath approach to treatment of cerebral palsy presented by two women from the United Cerebral Palsy Foundation, Miss Gertrude Wilkinson, physical therapist, and Mrs. M. J. Kirschling, physiotherapist, both associated with Howe Orthopedic School.

Dr. Thomas E. Lynn reported on the stroke syndrome committee of the Curative Workshop, and *Dr. L. H. Edelblute* announced that 92,000 people attended the second polio series, making a total of around 170,000 for the two feedings. The surplus of between $7,500 and $8,000 has been assigned to the United Fund of Brown County. The group voted to send a letter of commendation to *Dr. R. L. Myers*, who served as general chairman of the mass immunization project in Brown County.

Dr. M. D. Blackburn, Jr., gave the nominating committee report and read the following slate of new officers for 1965: *Dr. C. A. Wunsch*, president-elect; *Dr. K. C. Mickle*, secretary–treasurer; *Dr. A. J. McCarey*, censor 1965–1967; *Drs. B. P. Waldkirch* and *J. E. Dettmann*, delegates 1965–1966; *Drs. Donel Sullivan* and *J. B. Grace*, alternates 1965–1966.

Doctor Edelblute recommended an annual program of public recognition to two or three lay people whose services to the medical profession have been outstanding. Doctor Waldkirch briefly discussed the question of a clinical dean for the University of Wisconsin which came up at the October meeting.

Mr. Lawrence Ryder, regional representative of the State Medical Society, a guest at the meeting, stated that Kerr–Mills had been promoted by the SMS, and distributed a booklet on Wisconsin Kerr–Mills.

DANE

Following past custom, the November meeting of the Dane County Medical Society was held in conjunction with the Medical School staff at University Hospitals. Setting for the evening meeting was the State Medical Society headquarters building.

Delegates to the SMS House of Delegates reported on its Interim Session in October. Dr. James Crow, acting dean of the University of Wisconsin Medical School, spoke on "What's New at the U.?" E. J. Connors, superintendent at University Hospitals, discussed "Present Status of the Building Program." *Dr. William Kisken* of the Department of Surgery presented a talk on "Research in Organ Transplant," and *Dr. Robert O. Johnson*, also of the Department of Surgery, spoke on "Results of Treatment of Carcinoma of the Head and Neck with Slow Infusion of Chemotherapeutic Agents."

New members of the society are *Drs. Margaret Jean Seay, Robert F. Schilling, Walter R. Sundstrom*, and *Carl B. Weston*. Doctor Seay is employed at Mendota State Hospital; Doctor Schilling is chairman of the Department of Medicine at the University of Wisconsin Medical School; and Doctors Sundstrom and Weston are in private practice in Madison.

Physicians whose names appear in italics are members of the State Medical Society.

DOUGLAS

Officers were elected at the November 4 meeting of the Douglas County Medical Society in the Lakewood Room of the Saratoga Cafe in Superior. *Dr. Victor E. Ekblad* was named president-elect for 1965 and *Dr. Oscar A. Farias*, secretary-treasurer. President for 1965 is *Dr. Milton Finn*. Nineteen members were present.

At the society's meeting on October 14 at Middle River Sanatorium and Douglas County General Hospital, Hawthorne, Doctor Farias presented two cases treated as Pott's disease, which proved to be nontuberculous, and pulmonary tuberculosis treated with combined chemotherapy—success and failure. Twenty members attended.

GREEN LAKE–WAUSHARA

The October meeting of the Green Lake–Waushara County Medical Society was held on the 13th at Barnekow's Supper Club, Princeton, with 30 members present to hear the State Medical Society regional representative, Lawrence Ryder, speak on the Kerr–Mills law and related subjects.

MANITOWOC

The Manitowoc County Medical Society and the County March of Dimes chapter cosponsored the mass polio immunization program which got underway November 15 in Manitowoc County. *Dr. R. G. Strong*, Manitowoc, predicted that the number of county residents turning out for the Sabin oral polio vaccine at nine county locations would top the 45,000 mark when all attendance figures were compiled. A followup dosage for Types 2 and 3 is scheduled for January 10.

Plans for the feedings were discussed in October at a meeting in Manitowoc attended by, among others, *Dr. W. E. Acheson*, Valders; *Dr. J. E. Nilles*, Mishicot; *Dr. H. L. Gerndt, Jr.*, Manitowoc; *Dr. S. L. Weld*, Two Rivers; *Dr. Hendrik Leering*, Reedsville, and Doctor Strong. Details of the program were announced in advance by *Dr. C. E. Wall*, Manitowoc, society president.

MARINETTE–FLORENCE

Dr. Clarence H. Boren, second from left, received a plaque honoring him for 45 years of service to medicine and to the Marinette community November 4 at a dinner and reception sponsored by the Marinette–Florence County Medical Society at Riverside Country Club, Marinette. Presenting the award is Dr. Charles E. Koepp, president of the medical society, and looking on are Doctor Boren's two sons, Dr. James A. Boren, left, and Dr. Clark H. Boren, right.

MILWAUKEE

Dr. Robert F. Purtell took office as president of The Medical Society of Milwaukee County at its annual meeting and election of officers December 10 at the Milwaukee University Club.

Guest speaker for the meeting was Walter W. Belson, executive vice-president of the American Trucking Association, Washington, D. C. A native of Hartford and a 1925 graduate of Marquette University, Mr. Belson is a brother of *Dr. Harold J. Belson* of Manitowoc.

Members of the 1964 nominating committee, who were appointed by society president, *Dr. Robert S. Haukohl*, were *Drs. S. W. Hollenbeck*, chairman; *F. L. DeGroat, Jr., W. C. Fetherston, P. C. Guzzetta, Jr., E. T. Harrington, Gregory Inda, C. J. Junkerman, R. T. McCarty, F. J. Mellencamp, M. E. Sattler, D. K. Schmidt, H. F. Twelmeyer, L. B. Uszler* and *D. M. Willson*.

OUTAGAMIE

Dr. John T. Petersik, a former superintendent of Winnebago State Hospital, spoke on "Social Changes in Psychiatry," at the dinner meeting of the Outagamie County Medical Society November 19 in Alex's Manor House, Appleton. An Oshkosh psychiatrist, Doctor Petersik told the group that physicians should be more aware of the emotional needs of persons in their communities in order to be more effective in dealing with mental illness.

RACINE

Father John J. Higgins, professor at St. Louis University, St. Louis, Mo., discussed "Hypnosis in Modern Living" at the November 12 meeting of the Racine County Medical Society at Wingspread, Racine.

The society's annual meeting and election of officers took place November 24 at St. Luke's Hospital Auditorium.

RICHLAND

Dr. Thomas C. Meyer of University Hospitals, Madison, discussed "Congenital Heart Defects" at the meeting of the Richland County Medical Society November 9 in the Richland Hospital library.

ROCK

Rock County's tremendous response to the Sabin oral polio vaccine program will aid science programs in Beloit and Milton Colleges, it was revealed at a dinner meeting of the Rock County Medical Society October 27 at Beloit's Hotel Hilton. Each college received a check for $14,325, presented by *Dr. E. W. Reinardy*, Janesville, society president. Some 88,000 persons, more than 80 per cent of the county's population, took advantage of the mass immunization program sponsored by the medical society.

Dr. J. C. Springberg, Beloit city health commissioner, was chairman of the steering committee which planned the program. He was assisted by *Dr. J. R. Schroder* and *Dr. Thorn L. Vogel* of Janesville.

At a meeting after the dinner, *Dr. Lester Brillman*, Beloit, was elected president of the society for 1965. *Dr. Paul Odland*, Janesville, was elected vice-president, and *Dr. William A. Pruett, Jr.*, Beloit, was named secretary succeeding *Dr. Walter A. Scholten, Jr.*, Beloit.

TREMPEALEAU–JACKSON–BUFFALO

Election of officers featured the meeting of the Trempealeau–Jackson–Buffalo County Medical Society November 23 at Club Midway, Independence. Named to office were *Dr. Larry L. Hanley*, Whitehall, president; *Dr. John H. Noble*, Black River Falls, president-elect; *Dr. Elmer Rohde*, Galesville, delegate; *Dr. William E. Wright*, Mondovi, alternate delegate; *Dr. Eugene Krohn*, Black River Falls, secretary-treasurer; *Dr. Charles F. Meyer*, Independence, Charitable, Educational and Scientific Foundation trustee; *Dr. O. M. Schneider*, Blair, public relations officer, and *Dr. M. O. Bachhuber*, Alma, censor.

Arcadia was host for the dinner meeting, at which attendance was 14. The society's next meeting will be held January 4.

A new member is *Dr. Dudley E. Wilkinson*, Mondovi.

DETAILS ON PHOTOGRAPHY CONTEST AND BOWLING TOURNAMENT

Pages 25 and 55

Wisconsin Medical Alumni

How the gastrocamera is used for diagnosis of benign peptic ulcers was described by *Dr. John F. Morrissey* for 150 midwestern physicians attending the annual fall meeting of the Wisconsin Medical Alumni Association October 31 at the University of Wisconsin Medical Center, Madison.

Doctor Morrissey, who is assistant professor of medicine at the University medical school, told the assemblage the tiny camera is also u eful in the diagnosis of cancer, polyps, and gastritis.

Others speakers at the meeting included *Dr. Sture A. M. Johnson*, UW professor of medicine, "Cutaneous Lesions as They Reflect Systemic Disease;" and *Dr. William A. Kisken*, UW instructor in surgery, "The Treatment of Head and Neck Cancer with Intra-Arterial Infusion."

DR. WILLIAM L. COFFEY, Jr., Milwaukee, front row left, presented the "Gavel of Authority" for the Wisconsin Society of Internal Medicine to newly installed president, Dr. George E. Gutmann, Janesville. The transition took place during the Wisconsin Society of Internal Medicine Annual Meeting, October 9, at Delavan.

Others elected were: (front row) Drs. A. A. Quisling, Madison, named president-elect and John H. Wishart, Eau Claire, reelected secretary-treasurer. The Society Council members are, (back row) left to right, Drs. Edward K. Ryder, Madison; James W. Monier, Marshfield; and George R. Barry, Monroe. Dr. William G. Kendell, Fond du Lac, (not pictured) was elected to a three-year term on the Society's Governing Council.

Nearly 70 physicians from throughout Wisconsin attended the Annual Meeting which was held in conjunction with a two-day Scientific Program.

Wisconsin Radiological Society

The fifteenth annual meeting of the Wisconsin Radiological Society was held recently at the Dell View Hotel, Lake Delton. Guest speakers were *Dr. Lester W. Paul*, Madison, and Juan A. del Regato, Colorado Springs, Colo. Doctor Paul, professor, Department of Radiology, University, Hospitals, Madison, spoke about the Rim Sign in Cystic Bone Lesions. Dr. del Regato is director of the Penrose Cancer Hospital, Colorado Springs, and spoke about

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Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Surgery Versus Radiotherapy in the Treatment of Cancer of the Cervix.

Other speakers were *Drs. William Stead, F. Frank Zboralske, Joseph Wepfer*, Walter Gunn, all of Milwaukee; *Dr. Albert Kohn* of Stevens Point; *Dr. Andrew Crummy* and Dr. Gordon Kenney of Madison, and *Dr. Robert Feulner* of Waukesha.

Dr. Theodore Pfeffer of Milwaukee was elected president to succeed *Dr. Howard Bayley* of Beaver Dam. *Dr. Eugene Betlach*, Janesville, is president-elect and *Dr. Howard Mauthe*, Fond du Lac, was named vice-president. *Dr. Charles Benkendorf*, Green Bay, will continue as secretary and treasurer for the next year. *Dr. Gunnar A. Gundersen*, La Crosse, and *Dr. Gilbert Stannard*, Manitowoc, were elected to the board of directors and *Dr. Ralph Frank*, Eau Claire, to the board of censors. *Dr. Robert Feulner*, Waukesha, was reelected as councilor to the American College of Radiology with *Dr. Leslie Jones*, Racine, serving as the alternate.

New members accepted in the society were *Dr. A. M. Richter*, Waukesha; *Dr. Joyce Kline*, Madison; *Dr. Richard Lindgren*, Madison; *Dr. Thomas Hansen*, Janesville; *Dr. June DeBoer Unger*, Milwaukee; *Dr. Louis Plouff*, Appleton, and *Dr. Frederick Henke*, Eau Claire.

Dr. William T. Clark, Janesville, and *Dr. S. A. Morton*, Milwaukee, were elected emeritus members.

The program chairman was *Dr. John Amberg*, Milwaukee, and the registration committee was Mrs. Charles Benkendorf and Mrs. Howard Bayley.

Northern Branch, WPA

The Northern Branch of the Wisconsin Psychiatric Association served as host to the entire membership of the association October 24 and 25 at Green Bay.

Bill 170, S. and the relationship of private psychiatrists to public and private community progress were discussed by the principal speakers, *Dr. Leonard J. Ganser*, director of the state division of mental hygiene, Madison, and *Dr. Edward Houfek*, Sheboygan.

Dr. Charles A. Wunsch, Green Bay, was named president-elect of the Northern Branch. He also served on a panel with hospital administrator Lynn Lucia, Neil Webb of St. Norbert College and *Dr. James F. Caffrey*, all of Green Bay; *Dr. Keith M. Keane*, Appleton; and *Dr. Kenneth H. Rusch*, Madison.

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SPECIALTY PROCEEDINGS *continued*

Southern Chapter, WPA

Dr. Arnold M. Ludwig, who arrived in Madison last summer to become director of education and research at Mendota State Hospital, addressed the fall meeting of the Southern Chapter of the Wisconsin Psychiatric Association September 21 at Rohde's Steak House, Madison. Doctor Ludwig, who came to Wisconsin from the U. S. Public Health Service Hospital in Lexington, Ky., discussed work he has been doing with hypnosis and hallucinogenic drugs in drug addicts.

New officers of the chapter for the 1964–1965 season are: *Dr. Benjamin H. Glover*, president; *Dr. Gerald L. Clinton*, president-elect; Dr. Richard J. Thurrell, secretary; *Dr. William Buzogany*, treasurer; *Drs. Clemens S. Schmidt* and *Edwin O. Sheldon, Jr.*, counselors. All are of Madison.

Medical Assistants Convention

The Eighth Annual Convention of the American Association of Medical Assistants was held October 13–18 at the Sheraton-Oklahoma Hotel, Oklahoma City. Wisconsin was represented by 12 members, and *Dr.* and Mrs. *Daniel Dorchester* of Sturgeon Bay. Delegates from Wisconsin were Mrs. Aleen Piepenburg, Waukesha; Miss Alice Roelse, Port Washington; and Mrs. June Gillette, Sheboygan.

The convention centered on the role of the Medical Assistant in emergencies. A Leadership Symposium on the duties, responsibilities and legal aspects of the medical assistant, in a clinic, solo practice or community emergencies high-lighted the general session. Included was a Workshop on Certification for Medical Assistants, and Problem-Solving Clinics.

The Saturday noon luncheon speaker was Dr. Donovan Ward, president of the American Medical Association. Other outstanding speakers were Mr. Richard Bergen of the American Medical Association's legal department, whose topic was Legal Do's and Don'ts for Medical Assistants; Doctor Donald Cooper, director of Oklahoma State University Hospital and Clinic spoke on What Is Fitness? Guest speaker at the Saturday night banquet was Mr. G. Robert Gadberry of Wichita, Kan., whose subject was You Are The Difference.

Children with Behavioral Disorders Group

Dr. Leonard Ganser, Madison, director of the Division of Mental Hygiene of the State Department of Public Welfare, spoke at the fall institute of the Wisconsin Association of Children with Behavioral Disorders November 13 at Mendota State Hospital. One of the three who conducted workshops at the institute was *Dr. Martin B. Fliegel*, director of the Children's Treatment Center at Mendota.

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Dr. Curran To Head Medical Conference

Dr. W. P. Curran, Antigo, president of the State Medical Society, has been named president-elect of the North Central Medical Conference, which consists of the state medical societies in Wisconsin, Iowa, Minnesota, Nebraska, and North and South Dakota.

Dr. Green Joins Lynn Clinic

The Lynn Clinic, Green Bay, has announced the association of Dr. Jeremy R. Green, internist. Doctor Green's cosmopolitan background includes birth in the Republic of South Africa, where he attended medical school and interned in Johannesburg; a neurological residency in Ireland; three years of study in London, and faculty membership, during the 18 months preceding his arrival in Green Bay, in the department of medicine of the University of Melbourne in Australia. He has also undergone training at several hospitals in the United States.

Reelected by Cancer Society

Dr. John S. Hirschboeck, acting dean and vice-president of Marquette University School of Medicine, and *Dr. James E. Conley,* associate professor of surgery at Marquette, have been reelected to the board of directors of the American Cancer Society.

Dr. Tomkiewicz Is Speaker

"Don't ask too much of a retarded person," was the advice of *Dr. Ralph E. Tomkiewicz,* Bacon Clinic psychiatrist, as speaker October 26 in Union Grove before some 45 members of the Racine County Association for Retarded Children.

Wild Rose Clinic Opens

An open house was held November 8 at the new Wild Rose Clinic, third structure in the little community's imposing medical center. Partners in the clinic are *Drs. Roger A. Kjentvet, Rodney D. Wichmann,* and Shirley L. Hadden. The latter, whose dream was responsible for the construction of the Wild Rose Hospital in 1940 and 1941, returned to Wild Rose at the invitation of the other two doctors after spending nine years in Florida.

Dr. Buchman Joins Clinic Staff

Dr. D. M. Buchman, who has been practicing medicine in La Crosse since 1950, has joined the staff of the La Crosse Clinic. For the past four years, in addition to his private practice, Doctor Buchman was medical director at Oak Forest Sanatorium, Onalaska.

Dr. Guenther Leads Seal Sale

Dr. Vernon G. Guenther, board member of the Oshkosh Anti-Tuberculosis and Health Association, headed the 1964 Christmas Seal sale in Oshkosh.

Physicians whose names appear in italics are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Doctors Receive SS Pins

Four Sheboygan County physicians who serve as medical advisers to the county's Selective Service Board were presented with service certificates and pins in October. *Dr. Paul B. Mason,* Sheboygan, received a 20-year certificate and pin. Receiving 15-year certificates and pins were *Dr. H. J. Winsauer,* Sheboygan; *Dr. L. J. Steffan,* Plymouth; and *Dr. Harry H. Heiden,* Elkhart Lake.

Dr. Leicht at Stroke Congress

Dr. Thomas R. Leicht, Green Bay, attended the First National Congress on Strokes held October 29–31 at the Palmer House, Chicago.

Dr. Kline on Panel

Dr. Carl L. Kline, Wausau, medical director of the Marathon County Guidance Center, was a member of a panel which discussed "Psychiatric Emergencies in Communities of Under 100,000 Population" early in November at the second annual congress on mental health of the American Medical Association in Chicago.

Dr. Mueller Retires

Dr. Nina T. Mueller retired November 2 after 34 years with the Milwaukee health department. She was succeeded as superintendent and medical director of the department's tuberculosis section by Dr. Joseph C. Mulhern, Jr.

Madison Doctors Speak

Three Madison physicians, *Dr. Glenn J. Stuesser,* surgeon, *Dr. G. B. Tybring,* psychiatrist, and *Dr. R. A. Sievert,* rehabilitation specialist, were among the speakers November 4 when Madison clergymen and doctors held their annual meeting at Madison General Hospital.

Dr. Koepke Leaves UW

Dr. Donald E. Koepke, one of the University of Wisconsin Medical School's experts in cardiovascular surgery, has resigned from the faculty to become associated with *Dr. Charles S. Rife* at Milwaukee Hospital.

Oconomowoc Hospital Staff

Dr. Joseph R. Matt, Oconomowoc, has been elected president of the medical staff of Memorial Hospital, Oconomowoc, for the period from October 1964 to

September 1965. Other officers are *Dr. Clarence Samuelson*, Hartland, vice-president, and *Dr. John D. Wilkinson*, Oconomowoc, secretary-treasurer. Other members of the executive committee are *Dr. B. J. Schumacher* and *Dr. W. D. James*, both of Oconomowoc.

Dr. E. Grady Mills, Oconomowoc, has been elevated from the courtesy to the active staff, and Dr. Kenneth R. Fick, Milwaukee, anesthesiologist, has been newly appointed to the courtesy staff.

Photo courtesy Madison VA Hospital

AT A GATHERING OF THE staff and students of the Madison VA Hospital December 10, Dr. William S. Middleton, Madison, (right) was presented the first copy of the November issue of the *Wisconsin Medical Journal* which paid tribute to Doctor Middleton in the form of a Festschrift which is a collection of learned writings contributed by students, colleagues, and admirers to honor a distinguished scholar in the form of a celebration. Dr. G. A. Cooper, Madison, member of the Editorial Board who coordinated the special issue, made the presentation. Doctor Middleton is dean emeritus of the University of Wisconsin Medical School and recently retired chief medical director of the Veterans Administration. He was totally unaware of the special issue and was modestly surprised and pleased with its publication.

Dr. Walker Named Fellow

Dr. Duard L. Walker, professor of medical microbiology at the University of Wisconsin Medical School, Madison, has been named a fellow of the American Academy of Microbiology, Inc.

Dr. Holmgren Gets Dr. Jackson Post

Dr. Luther E. Holmgren has been elected president of the Jackson Foundation for Medical Education and Research in Madison succeeding Dr. Arnold S. Jackson, who died August 30. Recently, Foundation members also elected *Dr. William B. Parsons, Jr.*, to Doctor Jackson's place on the board of directors. Other directors include *Dr. George H. Ewell*, who was reelected vice-president.

Dr. Bourget Heads Staff

Dr. G. E. Bourget was elected president of the Hudson Memorial Hospital medical staff at its annual meeting in October. Also elected were *Dr. G. J. Hopkins*, vice-president, and *Dr. M. A. Cornwall*, secretary.

Dr. Schorr Dermatology Diplomate

Dr. William F. Schorr of the Marshfield Clinic has passed his American Board of Dermatology examination and is now a diplomate of the American Board of Dermatology.

Dr. Schroeder Addresses Group

"Sex Education for Young Children" was the topic presented by *Dr. R. W. Schroeder*, Fond du Lac, as speaker for the October meeting of the Childbirth Education Association Inc. at St. Agnes Hospital, Fond du Lac.

"Dr. Spencer D. Beebe Week" Notes 95th Birthday of Sparta Physician

For the citizens of Sparta, the third week in November was "*Dr. Spencer D. Beebe* Week."

In his proclamation issued in honor of Doctor Beebe's 95th birthday November 19, Mayor Ralph Osborne called the doctor "Sparta's oldest and most revered physician, respected, honored and loved by the entire community," and urged all citizens "to join me in honoring him on his birthday and for his contributions to the health and welfare of the city and to its civic and social advancements."

In an editorial congratulating Doctor Beebe, the Madison CAPITAL TIMES called him "an example of citizenship for all of us.

"Since 1896 he has been caring for the sick and feeble in his area of the state," the TIMES editorial continues. "But he has been more than a physician. He has been a counselor, confessor and shepherd for the countless people who sought help out of his wisdom and understanding."

Doctor Beebe is a past president of the State Medical Society of Wisconsin and a member of numerous Sparta organizations, one of which, the Kiwanis Club, honored him the week of his anniversary. He is a native of Sparta, where he was graduated from high school in 1889. He took his premedical training at the University of Wisconsin and received his M.D. degree from Rush Medical College in 1896. For five years he was located in Elroy, returning in 1901 to Sparta where he has practiced ever since. He and his wife, the former Cora Blakeslee, have four daughters and two sons, one of the latter adopted.

Anesthesiology Demonstration

Two Marshfield Clinic anesthesiologists, *Dr. Donald P. Pederson* and *Dr. Donald M. Kinkel*, demonstrated the use of an anesthetic on a laboratory rat

November 2 at the Clinic for 40 science students and faculty members from the two Marshfield high schools. The Marshfield Clinic Foundation sponsored the meeting, which was the first of a series.

Dr. Peterman Takes US Post

Dr. Mynie G. Peterman, a leading Milwaukee pediatrician for 39 years, left his private practice at the end of October to take a post with the U. S. Food and Drug Administration in Washington, D. C.

Dr. Purdy Program Moderator

Dr. Marshall F. Purdy, Janesville internist, was program moderator for the seminar of clergymen and physicians held November 4 at the Red Barn Country Club of the Wagon Wheel, Janesville, under the sponsorship of the Wisconsin Heart Association's Rock County unit and the Illinois Heart Association. Among the speakers was *Dr. Edward E. Houfek*, Sheboygan psychiatrist.

Dr. Sun in New Office

Since early November, *Dr. Kwoh Cheng Sun* has been receiving clinical patients in his new office on highway 35 just bordering the southern limits of the village of Siren.

Dr. Walker Named Diplomate

Dr. Duard L. Walker, Madison, professor of microbiology in the University of Wisconsin Medical School, has been named a diplomate in public health and medical laboratory virology by the American Board of Microbiology.

Group Hears Dr. Lawton

Dr. Ben R. Lawton of the Marshfield Clinic addressed the Oconto Falls Businessmen's Association October 8 at a meeting at the Round Roof Club, Kelly Lake.

Dr. Fencil Elected

Dr. Wayne J. Fencil of Monroe was elected president of the Monroe Kiwanis Club at its annual meeting late in October at the Swiss Wheel, Monroe.

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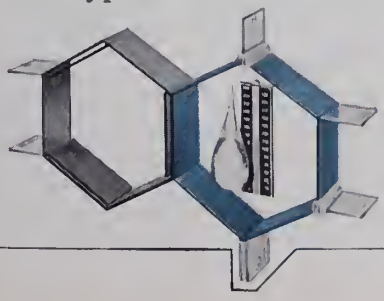

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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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Cancer Research Gift to UW

A GIFT OF $10,000 FOR CANCER RESEARCH purposes was presented to the University of Wisconsin in late September by the National Organization of the Ladies' Auxiliary to the Veterans of Foreign Wars in honor of Mr. and Mrs. William Campbell of Neenah. Mrs. Campbell, who served the organization as president in 1963–64, herself made the presentation to UW President Fred Harvey Harrington (right) in Madison. University officials, including Dr. James F. Crow, acting dean of medicine (left), and VFW members were on hand for the presentation in President Harrington's office. The contribution to research was accepted formally by the UW regents at their September meeting. Since 1947 the auxiliary has donated nearly a million dollars to cancer research programs and to members suffering from the disease.

Photo courtesy OSHKOSH NORTHWESTERN

DR. RUSSELL C. DARBY, Wautoma, left, and Dr. Roy Hong, Wild Rose, were presented pins and certificates November 4 in recognition of their 15 years of service as uncompensated medical advisers of the Waushara County Selective Service system. Wautoma Mayor Clarence Peterson made the presentations and taking part, also, was James O. Eagan, right, Neshkoro, chairman of the selective service board.

Wisconsin Physicians Participate

Several Wisconsin physicians participated in the meeting of the American College of Obstetricians and Gynecologists, District VI, October 29–31 at the Marlborough Hotel, Winnipeg, Canada.

Dr. Alwin E. Schultz, Madison, presented a paper on "Inadequate Surgery in the Treatment of Invasive Carcinoma of the Cervix," and three Wisconsin doctors participated in panels. *Dr. Ben M. Peckham,* Madison, served on a panel on "Pelvic Pain" and *Drs. Richard F. Mattingly,* Milwaukee, and *Herbert F. Sandmire,* Green Bay, were on the panel on "Geriatric Gynecology." Dr. John C. Scott, Milwaukee, appeared by invitation as a discussant on the afternoon program October 29.

Dr. M. Alex Krembs, Milwaukee, is chairman of the District VI Wisconsin section and *Dr. Russell F. Lewis,* Marshfield, is vice-chairman. President of the Wisconsin Society of Obstetrics and Gynecology is *Dr. Leo R. Grinney,* Racine, and *Dr. Raymond E. Whitsitt,* Madison, is secretary.

Nurses Hear Dr. Treffert

Dr. Darold A. Treffert, Fond du Lac, superintendent of Winnebago State Hospital, addressed the conference group on psychiatric nursing at the annual convention of the Wisconsin Nurses Association October 7 at the Hotel Schroeder, Milwaukee. Doctor Treffert's topic was "Emotional Problems of the Adolescent."

Heart Unit Honors Dr. Quick

Dr. Armand J. Quick, former chairman of the biochemistry department of Marquette University School of Medicine, was honored by the research committee of the American Heart Association November 10 for his development of the Quick prothrombin test.

Dr. Clark Still Practicing

Though he has closed his downtown office in Janesville, *Dr. W. T. Clark,* 82-year-old veteran of 57 years in radiology and general practice, is still as active as ever. He merely has moved his office to his home on Atwood Avenue, where he is carrying on a practice that has spanned most of the major developments in x-ray and radiology.

Dr. Burns Is Speaker

Dr. R. O. Burns, Madison, discussed "Peritoneal Dialysis" at the meeting of the Middleton Nurses' Study group October 6 at the home of Mrs. C. P. Rohan, Madison.

Horicon Rotary Hears Dr. Klomberg

The many breakthroughs in medicine which have prolonged human life were pointed out to members of the Horicon Rotary Club by Dr. Gerald H. Klomberg, Beaver Dam internist, at a meeting in October at Horicon.

Drs. Wall, Boyle Named

Dr. Charles E. Wall, Manitowoc, president of the Manitowoc County Medical Society, and *Dr. Robert W. Boyle,* director of physical medicine and rehabilitation, Milwaukee County General Hospital, have been named to the Wisconsin Kenny Rehabilitation Council, a newly-formed unit organized by the Kenny Rehabilitation Foundation.

Alumni Group Hears Dr. Schilling

Dr. Robert F. Schilling, professor and chairman of medicine at the University of Wisconsin Medical School, Madison, was the main speaker at the North Central Medical Alumni meeting November 11 in Wausau.

Dr. Angevine Elected

Dr. D. Murray Angevine, professor and chairman of pathology at the University of Wisconsin Medical School, Madison, was recently elected to the board of directors of the Wisconsin Chapter of the Arthritis Foundation.

Wisconsin Physicians at AHA Meeting

Among the seven delegates the Wisconsin Heart Association sent to Atlantic City, N. J., October 25–27 for the annual meeting of the American Heart Association were four Wisconsin physicians: *Dr. William B. Hildebrand,* Menasha, WHA president; *Dr. Hugh J. McLane,* Fond du Lac, chairman of the community service and education committee; *Dr. George G. Rowe,* Madison, chairman of the research committee; and *Dr. Derward Lepley, Jr.,* Milwaukee, chairman of the physician education committee.

At the scientific session on October 25, a team of WHA research scientists from Madison presented a paper on the Gott–Daggett artificial heart valve. They were: *Drs. Vincent L. Gott, George G. Rowe,* James D. Whiffen, and *William P. Young,* and Prof. Ronald L. Daggett.

Dr. Warpinski in New Office

Since the first of October, *Dr. M. A. Warpinski* has conducted his practice in new quarters, the St. Agnes Medical Center in Green Bay. He formerly was associated with the West Side Clinic, and the Brusky Clinic.

—Photo courtesy APPLETON POST-CRESCENT

NEW OFFICERS of Appleton Memorial Hospital's medical staff study reports at the hospital's conference room. From left are Dr. George P. Nichols, chief of staff; Dr. Pearse P. Meighan, secretary-treasurer; and Dr. Paul C. Hodges, Jr., vice-chief of staff.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF OCTOBER 15, 1964

NEW MEMBERS

Douglas W. Bailey, 161 West Wisconsin Avenue, Milwaukee.
Michael J. Belson, 130 East Walnut Street, Green Bay.
John R. Benfield, 1300 University Avenue, Madison.
Larry C. Carey, 152 North 92nd Street, Milwaukee.
James Connolly, Thorp Medical Center, Thorp.
Henry L. Dale, 2679 North Teutonia Avenue, Milwaukee.
Robert C. Danforth, 208 East Wisconsin Avenue, Milwaukee.
Robert E. Dedmon, 211 North Commercial Street, Neenah.
Peter J. Groessl, 645 South Monroe Street, Green Bay.
George R. Kaftan, 205 East Walnut Street, Green Bay.
David L. Lawrence, Sharpe Clinic, Fond du Lac.
Allan Luck, 1206 West Mitchell Street, Milwaukee.
John T. McManus, U.S.A.H., Dept. of Radiology, Fort Jackson, S.C.
John D. McMaster, 1300 University Avenue, Madison.
Abdallah G. Melkonian, 2266 North Prospect Avenue, Milwaukee.
James C. Payne, 404 North Main Street, Oshkosh.
Thomas A. Phillips, Medical Center, Owen.
Arthur C. Plautz, Jr., 4835 West Capitol Drive, Milwaukee.
Robert I. Reichle, 7 West 12th Street, Clintonville.
Howard T. Rosenbaum, 1300 University Avenue, Madison.
Frederick Schaefer, 59 Racine Street, Menasha.
John P. Schumacher, 210 South Monroe Avenue, Green Bay.
Dale R. Shampo, Richland Medical Center, Richland Center.
Charles O. Slocumb, P.O. Box 207, Twin Lakes.
L. Gilbert Thatcher, 1300 University Avenue, Madison.
Joseph M. Tobin, 605 Walker Avenue, Eau Claire.
Donald A. Treffert, 52 Sheboygan Street, Fond du Lac.
Roger L. Von Heimburg, 205 East Walnut Street, Green Bay.
John C. Weber, 3321 North Maryland Avenue, Milwaukee.
Floyd M. Zarbock, 720 North Rochester Street, Mukwonago.

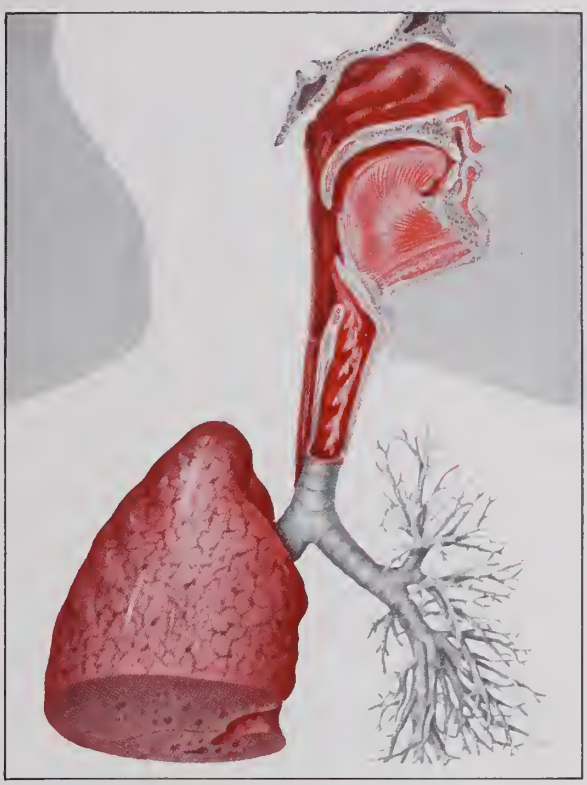
CHANGES OF ADDRESS

Alois M. Bachhuber, 1015 West Wisconsin Avenue, Kaukauna.
Richard O. Barnes, 6000 South 27th Street, Milwaukee.
Edgar J. Behnke, 4103 West North Avenue, Milwaukee.
C. H. Belcher, Box 916, Hilo, Hawaii.
Kenneth A. Bittle, Winnebago, to Patton State Hospital, Patton, Calif. 92369.
Philip A. Bond, 3975 North 68th Street, Milwaukee.
Domenick S. Bruno, 4611 North Oakland Avenue, Milwaukee.
S. D. Carlson, Milwaukee, to 1121 East Lexington Boulevard, Eau Claire.
William T. Casper, 4222 West Capitol Drive, Milwaukee 53216.
Donald P. Davis, Beckley, W. Va., to 3566 North Frederick, Shorewood.
Cornelis Dekker, Box 367, Genoa City.
Ralph G. Dorn, Madison, to 3249 North 48th Street, Milwaukee.
Paul J. Fitzpatrick, Colorado Springs, Colo., to 208 Esther Drive, Security, Colo.
K. L. German, 515 South Barstow, Eau Claire.
Calvin J. Gillespie, Milwaukee, to Fidelity Bank Building, Antigo.
Robert J. Goldberger, Vandenberg AFB, Calif., to Monterey County Hospital, Salinas, Calif.
Thomas G. Haugh, Newberry, Mich., to R.F.D. # 1, Waunakee.
Alford H. Hermann, 5201 West Center Street, Milwaukee.
John Frank Imp, 10126 West Good Hope Road, Milwaukee.
Marshall R. Jennison, Milwaukee, to 17755 Senlac Lane, Brookfield.
Rhoda E. Johnson, 1732 North Prospect Avenue, Milwaukee.
Jack L. Kinsey, Washington, D.C., to 1111 Army Navy Drive, Apt. C511, Arlington, Va. 22202.
Robert E. Klingbeil, Milwaukee, to 12750 Green Meadow Place, Waukesha.
John R. Larsen, Madison, to EENT Clinic, USAH, Fort Leonard Wood, Mo.
Craig Larson, Milwaukee, to V.A. Hospital, Wood.
M. S. LeTellier, 416 Arrowhead Drive, Green Bay.
Isadore Mallin, 3400 West Laurence Avenue, Chicago, Ill. 60625.
John E. McKenna, 837 Clermont Street, Antigo.
Owen E. Miller, 217 Wisconsin Avenue, Waukesha.
John P. Mullooly, 411 East Mason Street, Milwaukee.
Philip G. Piper, 925 Mound Street, Madison.
Charles L. Qualls, St. Joseph's Hospital, Beaver Dam.
Felipe L. Qui, 751 Daffodil Lane, Beloit.
I. B. Reifenrath, 10425 West North Avenue, Milwaukee.
William E. Reifenrath, 10425 West North Avenue, Milwaukee.
James A. Schelble, 2320 North Lake Drive, Milwaukee.
Robert A. Schmidt, 400 West Silver Spring Drive, Milwaukee.
Rudolph J. Scriment, Guantanamo Bay, Cuba, to 111 East Wisconsin Avenue, Milwaukee.
R. G. Simion, 114 South Park, Reedsburg.
W. W. Stebbins, Madison, to 222—8th Avenue North, St. Petersburg, Fla.
Peter Torbey, Gothenberg, Sweden, to 4004 Santa Anita Drive, El Paso, Tex.
R. C. Wheaton, 417 Milwaukee Avenue, Burlington.
Robert M. Wheeler, Madison, to 4209 N.E. 21st Avenue, Fort Lauderdale, Fla.
E. N. Wright, 2121 Bowen Street, Oshkosh.
M. D. Yatso, 7305 Grand Parkway, Milwaukee 53213.

REMOVED FROM MEMBERSHIP

Jerome J. Dowling, Milwaukee County, transferred to Maryland.
Edward I. Feldman, Milwaukee County, transferred to California.
William P. G. Jones, Milwaukee County, transferred to Hawaii.
Bernard C. Korbitz, Dane County, transferred to Colorado.

WHEN CONGESTION MOVES DOWN



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Pyrilamine maleate		12.5 mg.
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Ammonium chloride		60 mg.
Sodium citrate		85 mg.

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CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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SOCIETY RECORDS *continued*

Calvin G. Maloney, Jefferson County, transferred to California.
James J. Nora, Dane County, resigned.
William E. Prickman, Dane County, transferred to Minnesota.
Robert C. Tabet, Milwaukee County, transferred to Ohio.
Benjamin Wein, Milwaukee County, resigned.

DEATHS

Joseph P. Healy, Pierce—St. Croix County, August 31, 1964.
Mary P. Gratiot, Lafayette County, September 4, 1964.
Milton Feig, non-member, September 20, 1964.
Gerald F. McKay, Milwaukee County, October 1, 1964.
Jeffrey J. Brook, Milwaukee County, October 8, 1964.
Max E. J. Wiese, Milwaukee County, October 10, 1964.

1965 Special Annual Meeting Feature!

PHOTOGRAPHY CONTEST

For details and Entry Form see page 25 of this issue.

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OBITUARIES

Dr. May Raynolds Wells, Belleville, Ill., died February 9, 1964, at the age of 86.

A native of Mankato, Kan., Doctor Wells was a member of a family which boasted several physicians. She was the widow of Dr. S. E. Wells, with whom she practiced from 1905 to 1921 in Kansas City, Mo.; sister of the late Dr. E. L. Raynolds, Mankato, Kan., physician; a cousin of the late Dr. Sylvia Rose, and a niece of the late Dr. D. R. Seymour, both of Ionia, Kan. Following her husband's death she moved to Madison, where she practiced for a time.

She received her medical education at Eclectic Medical University, Kansas City, Mo. (a school which was then fully accredited but is now no longer in existence). Following her graduation in 1904, she interned at Kansas City until 1906. She was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and its "50 Year Club," and the American Medical Association. She also belonged to the Mississippi Valley Medical Society and attended the meetings when held in St. Louis as long as she was able. While in Kansas City, Mo., she was a member of the Jackson County Medical Society.

Surviving is a daughter, Mrs. Francis W. Swantz, Belleville, Ill.

Dr. George T. Hegner, native of Eden and a retired Appleton physician and surgeon, died May 25, 1964, at the age of 77.

He received his M.D. degree in 1909 from Marquette University School of Medicine and interned at Milwaukee County Hospital before becoming house surgeon at Johnston Emergency Hospital, Milwaukee. In 1912 he located in Appleton, where he became a member of the medical staff of St. Elizabeth Hospital, and at the time of his death was chairman of the staff executive committee.

In 1949, Doctor Hegner received the Marquette University Alumni Association meritorious service award. He was a fellow of the American College of Surgeons, founder of the Wisconsin Surgical Society, a member of the Outagamie County Medical Society, which he had served both as president and secretary, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Florence, and a son, William F. Hegner, Appleton.

Dr. Alexander F. Harter, a native of Campbellsport and a retired eye, ear, nose, and throat specialist in Rhinelander, died May 25, 1964, at the age of 82 years.

A 1904 graduate of the Wisconsin College of Physicians and Surgeons, Milwaukee, Doctor Harter took his internship at St. Francis Hospital, La Crosse, and practiced in Marathon City and Wausau before joining the Schiek Clinic in Rhinelander in 1926. He was chief of staff at St. Mary's Hospital in that city.

Doctor Harter was a member of the Oneida–Vilas County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology. In 1954, he was made a member of the state society's "50 Year Club."

Surviving is a daughter, Mrs. Frank Mancina, Eveleth, Minn.

Dr. William C. Maas, Rio, died June 5, 1964, at the age of 80.

A native of Cambria, Doctor Maas was a 1912 graduate of Marquette University School of Medicine and interned at Milwaukee Maternity Hospital. He practiced in Milwaukee before locating in Rio in 1916.

In 1962, he was granted membership in the "50 Year Club" of the State Medical Society of Wisconsin. He was also a member of the Columbia–Marquette–Adams County Medical Society and the American Medical Association. He had served as health officer for the Village of Rio, and from 1920 to 1947, he was clerk of the Rio school board.

Surviving are his widow; a son, William H., Milwaukee, and three daughters: Mrs. Orlo Patchin, Wyocena; Mrs. Richard Powell, Waukesha; and Mrs. L. B. Severson, Rio.

Dr. Harry H. Schlomovitz, Milwaukee, died June 10, 1964, at the age of 65.

Born in Milwaukee, he received his M.D. degree in 1923 from the University of Pennsylvania and interned at Fordham Hospital, New York City. His residency was served at the Mayo Clinic, Rochester, Minn. He was a partner in the Barron Clinic from 1927 until 1942, when he became the first physician from his community to enlist for service in World War II. He was discharged with the rank of major in January 1946, after serving in the American and Asiatic-Pacific Theaters and winning a Bronze Star for the New Guinea and Luzon Campaigns.

Following his retirement from the army on account of disability, he lived in Milwaukee. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

A brother, Dr. Benjamin H., Milwaukee, and a sister, Mrs. Ben Lesk, Miami Beach, Fla., are the sole family survivors.

Dr. Philip J. Eisenberg, 69, founder, president and chief of staff of West Side Hospital, Milwaukee, died June 11, 1964.

The Russian-born physician came to Milwaukee as a child and attended Marquette University before going on to Loyola University Medical School, Chicago, where he received his medical degree in 1917. He interned at Philadelphia General Hospital, Philadelphia, Pa., took his residency at Johnston Emergency Hospital, Milwaukee, and did postgraduate work in surgery and orthopedics in Vienna, Austria.

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residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

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(Warning: May be habit forming)

"PAIN & SPASM"
– a two-headed dragon!

ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to any component of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

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A Tribute to Dr. Ovid Meyer by Dr. M. H. Wirig

EDITOR'S NOTE: *Ironically, a letter was received at the State Medical Society office from Dr. M. H. Wirig on the day Doctor Wirig passed away. The letter contained a tribute to Dr. Ovid Meyer. It was Doctor Wirig's wish that it be published in the Wisconsin Medical Journal. The following are excerpts from the letter.*

"I was informed recently that Dr. Ovid Meyer is retiring* from his position as Chairman of the Department of Medicine of the University of Wisconsin Medical School and the Wisconsin General Hospital. This grieves me no end because we have been intimately associated since 1929 and 1930 and then on through the many years that followed when he was making his mark in medicine and I was trying to make my mark as a surgeon in the outside world.

"I think that all doctors will agree that have contact with him that he is the finest doctor that Wisconsin has produced and has trained. He has many attributes. One is steadfastness, a love of medicine, and his idealism portrays many and all of Osler's direction to his students. He stood far and ahead of the rank and file of the medical profession. He certainly established a tremendous Department of Medicine.

"Now mind you, he was working under an extreme handicap. His predecessor was Dr. William Middleton who had no peer. We all recognized Doctor Middleton as the finest and Dr. Ovid Meyer was somewhat humiliated by the fact that he had to proceed in the footsteps of Doctor Middleton and had to give of himself sufficient mental and physical amounts which were sometimes insurmountable but, believe me, even though Doctor Middleton stands as are (our) Number one physician, Dr. Ovid Meyer ranks right up there almost head and neck with Doctor Middleton. Doctor Middleton was much better known than Doctor Meyer. Doctor Meyer, of course, was limited should I say but he confined his activities to the Wisconsin Campus and was not known too well throughout the Medical Centers of the United States.

"His teaching, of course, was outstanding. He was a stimulus to his students and he extracted 'a pound of flesh' as it were to stimulate the students to a better understanding and then better acquainting themselves with their problems at hand.

"My relationship with Dr. Ovid Meyer goes back to when I was an intern and he was a resident. In a lighter mood I can assure you that Doctor Meyer was full of fun, jovial at times, . . . Ovid was sort of an organizer for some of the residents and interns . . . I could go on describing many hilarious situations because we really had fun during that time . . .

"But surprisingly Ovid outgrew those silly phases that a young man who is interested in medicine particularly goes through and he became a polished gentleman one who had an extraordinarily good mind—a mind that could fathom into the deep and come up with some most unusual diagnoses.

"He was the finest, and I am sure his students idolize him and his patients love him dearly for his kindness, his astuteness, and his scintillating mannerism in pursuing an elusive diagnosis. He is kind to the utmost and generous of himself which is a fault many times in our finer doctors because they must of necessity spread themselves a little more thinly than they should. He is one of Wisconsin's finest citizens and I salute him with my heart and soul knowing that in my mind and in many minds of the Medical Profession of the State of Wisconsin he is one of Wisconsin's finest."

* Doctor Meyer is now devoting full time to teaching, investigation and his patients.

OBITUARIES *continued*

He founded West Side Hospital in 1923 and had been president of the board since then, and chief of staff at various times, serving continuously in that position since 1954.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and the Central States Society of Industrial Medicine and Surgery.

Survivors include his widow, Beatrice; a daughter, Mrs. James R. Fitzsimmons, Milwaukee; and two sons, Dr. Marvin P., Santa Cruz, Calif., and Donald, Madison.

Dr. Marres H. Wirig, Madison, died June 15, 1964, at the age of 63.

A native of Antigo, Doctor Wirig had been a Madison practitioner since 1931. He received his medical degree in 1928 from Northwestern University, Evanston, Ill., interned at Wisconsin General Hospital and took his residency at St. Mary's Hospital, Madison. He was a past president of the staff of St. Mary's.

In addition to his membership in the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, Doctor Wirig was a fellow of the American College of Surgeons and a member of the College of Chest Physicians and the Wisconsin Surgical Society.

Survivors include his widow, Eleanor; three daughters, Mrs. Edward M. Jacobs, Beaver Dam; Joan Wirig, North Riverside, Ill., and Martha, at home; and two sons, Peter and Marc, at home.

Dr. Ernest A. Strakosch, 54, Oshkosh dermatologist, died June 24, 1964.

Born in Vienna, Austria, Doctor Strakosch attended the University of Vienna Medical School before coming to the United States in 1930. He received his M.D. degree in 1942 from the University of Minnesota, served his internship at the University of Iowa, Iowa City, and took further graduate work at the University of Minnesota. He held M.S. and Ph.D. degrees from the latter university.

From 1943 to 1944 Doctor Strakosch was on duty with the U.S. Public Health Service, acting as deputy chief to the late Dr. Paul A. O'Leary of the Mayo Clinic, Rochester, Minn. He practiced in Denver, Colo., from 1944 until 1955, when he moved to Oshkosh.

He was a diplomate of the American Board of Dermatology and Syphilology and a member of the Wisconsin Dermatological Society, Minnesota Dermatological Society, American Academy of Dermatology, Winnebago County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

Among those surviving are his widow, Helen; and two daughters, Christine and Pamela, Denver.

Dr. Leo M. Lifschutz, 58, chief of staff of St. Mary's Hospital, Racine, died July 4, 1964.

Doctor Lifschutz was born in Brooklyn, N.Y., and received his medical education from the University of Wisconsin Medical School, where he was granted his degree in 1932. He interned at Mt. Sinai Hospital, Milwaukee.

He was a member of the Wisconsin Academy of General Practice, the Wisconsin Society of Obstetrics and Gynecology, the Racine County Medical Society (which awarded him a plaque for outstanding achievements during a term he served as president), the State Medical Society of Wisconsin, and the American Medical Association. During World War II he was a captain in the Medical Corps.

Surviving are two sons, Michael and Mark, Racine.

Dr. Paul J. Dailey, Elcho physician and surgeon for a half century, died August 5, 1964, at the age of 76.

Born in Birnamwood, Doctor Dailey was graduated from Marquette University School of Medicine in 1913 and entered practice in Elcho that same year. In 1963, he was singled out for honors by the Langlade County Medical Society (which at one time he served as president) for his 50 years of service in the medical profession, and that same year he was granted life membership in the State Medical Society of Wisconsin. He was also a member of the American Medical Association and the American Railway Surgeons.

In June of 1953, Elcho honored him on his 65th birthday with a gala "Dr. Dailey Day" sponsored by the Women's Auxiliary of the Elcho American Legion Post.

Following in his footsteps is a son, Dr. Dee W. Dailey, who joined his father in practice in 1946. Also surviving is another son, Paul, Elcho.

Dr. Sidney H. Wetzler, one of Milwaukee's oldest physicians and a native of that city, died August 5, 1964, at the age of 81.

A 1905 graduate of Rush Medical School, Chicago, he served his internship at Cook County Hospital in the same city. Much of his practice was in industrial surgery. He was a former chief of staff and head of the department of surgery at Mt. Sinai Hospital, Milwaukee.

Doctor Wetzler was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, which in 1958 granted him life membership, the American Medical Association, National Industrial Physicians and Surgeons, and the Cook County Hospital Intern and Resident Association.

Surviving is a daughter, Mrs. Michael Shutkin, Los Angeles, Calif.

Dr. Thomas Sheldon Burdon, Green Bay physician and surgeon since 1932, died August 6, 1964, at the age of 61.

A Green Bay native, he received his medical degree in 1931 from the University of Wisconsin Medical School at Madison, and served his internship at St. Louis City Hospital No. 1, St. Louis, Mo.

He was a member and past president of the Brown County Medical Society (the Brown–Kewaunee–Door County Medical Society at the time he headed the organization), a member of the State Medical Society of Wisconsin, and the American Medical Association. He was a staff member and past president of St. Vincent, St. Mary, and Bellin Memorial Hospitals in Green Bay.

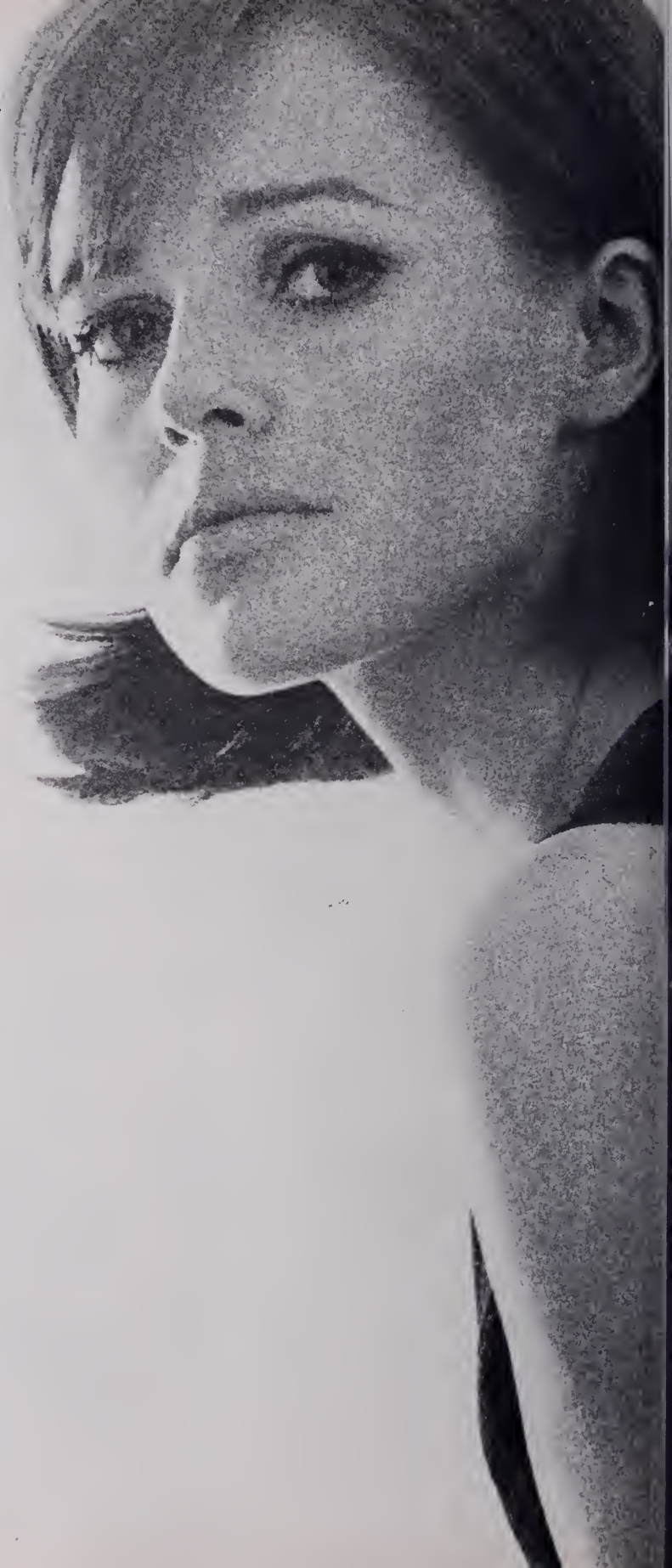
Surviving are his widow, Agatha, and four children.

Dr. Gerald F. McKay, 36, Milwaukee, died October 1, 1964.

Born in Milwaukee, Doctor McKay was a 1955 graduate of the University of Wisconsin Medical School. He served his internship at St. Joseph's Hospital, Marshfield, and his residency at Milwaukee County Hospital, where he was a clinical pathologist at the time of his death. From August 1956 to August 1958 he served in the Medical Corps of the U.S. Army. He was a junior member of the College of American Pathologists, and a member of the American Association of Blood Banks, the Wisconsin Association of Blood Banks, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American Society of Clinical Pathologists. He was also on the staff of the new Menomonee Falls Community Memorial Hospital, and a newly-appointed assistant professor of pathology at Marquette University School of Medicine.

Among his survivors are his widow, Elizabeth; three sons, Donald, Michael, and Thomas; and a daughter, Kathleen.

too young to be so tired...



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MEDICAL MEETINGS

POSTGRADUATE COURSES

1965 **Wisconsin**

Jan. 23–24: Triological Society, Wisconsin Center, Madison.

Jan. 28: U. W. "In Depth" program—Surgery: "Colon and Rectal Surgery in Children and Adults"—at University Hospitals and State Medical Society, Madison.

Feb. 5–6: Wisconsin Psychiatric Association, annual scientific meeting, Coach House Motor Inn, Milwaukee.

Feb. 6: Sixth Annual Educational Symposium, Wisconsin State Medical Assistants Society, at State Medical Society headquarters, Madison.

Feb. 17: U. W. "In Depth" program—Orthopedics: "Congenital Hips and Foot Deformities in Children" —at University Hospitals and State Medical Society, Madison.

Mar. 17–18: Wisconsin Hospital Association, Schroeder Hotel, Milwaukee.

Mar. 18: U. W. "In Depth" program—Obstetrics and Gynecology: "Endocrine Problems in Gynecology"—at University Hospitals and State Medical Society, Madison.

Mar. 19: Small Hospital Seminar, Schroeder Hotel, Milwaukee.

Apr. 1–2: Wisconsin Anti-Tuberculosis Association, annual meeting, Coach House Motor Inn, Milwaukee.

Apr. 1–3: University of Wisconsin Department of Pediatrics, annual postgraduate seminar, "Importance of Immune Mechanisms in Clinical Pediatrics," Wisconsin Center, Madison.

Apr. 3: Wisconsin Thoracic Society (WATA medical section), annual meeting, Coach House Motor Inn.

Apr. 5–8: National Association of Recreational Therapists, annual institute, Wisconsin Center, University of Wisconsin, Madison.

May 4–6: State Medical Society Annual Meeting, Milwaukee.

May 15: Wisconsin Heart Association, 17th annual meeting and scientific sessions, Coach House Motor Inn, Milwaukee.

June: Wisconsin State Medical Assistants Society, Coach House Motor Inn, Milwaukee.

1965 **Out-of-State**

Jan. 14–16: Postgraduate course in Dermatology in General Practice, sponsored by the Mound Park Hospital Foundation, 701 Sixth Street, South, St. Petersburg, Fla. 33701.

Jan. 17–23: University of Colorado School of Medicine, 11th annual general practice review, Denver.

Jan. 20–22: American Diabetes Association, in cooperation with Diabetes Association of Greater Chicago, 12th postgraduate course, "Diabetes in Review: Clinical Conference," Drake Hotel, Chicago.

Jan. 22–Feb. 4: International College of Surgeons, Caribbean surgical congress, aboard the S. S. Santa Paula, La Guaira, Curacao, Aruba, and Kingston.

Jan. 25–28: 24th research conference in pulmonary diseases of Veterans Administration–Armed Forces (formerly conference on chemotherapy of tuberculosis), LaSalle Hotel, Chicago, Ill.

Jan. 25–30: Workshop in Teratology, University of California, Berkeley.

Feb. 1–5: American College of Chest Physicians, postgraduate course in recent advances in diagnosis and treatment of diseases of heart and lungs, Hotel Fontainebleau, Miami Beach, Fla.

Feb. 4–5: Symposium on Noise in Industry, Institute of Industrial Health, at Kettering Laboratory, Cincinnati, Ohio.

Feb. 10–13: American College of Radiology, Philadelphia, Pa.

Feb. 15–17: American College of Surgeons, sectional meeting, Bellevue–Stratford Hotel, Philadelphia, Pa.

Feb. 15–18: Medical Society of the State of New York, 159th annual convention, The Americana, New York City.

Feb. 15–19: American College of Physicians, postgraduate course No. 7, pathology, pathologic physiology, and clinical aspects of renal disease, Presbyterian–St. Luke's Hospital, Chicago, Ill.

Feb. 20–23: University of Utah College of Medicine, annual postgraduate course in anesthesiology, Salt Lake City.

Feb. 22–26: American College of Physicians, postgraduate course No. 8, pain and addiction, Massachusetts General Hospital, Boston, Mass.

Mar. 13–18: International Academy of Proctology, 17th annual teaching seminar, Jung Hotel, New Orleans, La.

March 15–20: University of Colorado School of Medicine, 6th postgraduate course in medical technology.

Mar. 28–Apr. 1: International Anesthesia Research Society, 39th congress, Washington, D. C.

Mar. 29–Apr. 10: Postgraduate course in laryngology and bronchoesophagology given by Department of Otolaryngology, College of Medicine of University of Illinois, at Illinois Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, Ill.

Apr. 5–8: American College of Obstetricians and Gynecologists, annual clinical meeting, San Francisco, Calif. Postgraduate courses, Apr. 3–4.

Apr. 5–8: American industrial health conference, sponsored by Industrial Medical Association and American Association of Industrial Nurses, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Apr. 12–16: American College of Obstetricians and Gynecologists, Section of Hawaii, "Meeting on Maui."

May 31–June 2: American Thoracic Society, medical section of National Tuberculosis Association, Chicago.

June 17–21: American College of Chest Physicians, 31st annual meeting, Waldorf–Astoria Hotel, New York, City.

June 20–24: American Medical Association, Section on Radiology, New York City.

July 10–17: Sixth International Conference on Health and Health Education, Madrid, Spain.

Aug. 22–27: American Academy of Physician Medicine and Rehabilitation, annual meeting, Sheraton Hotel, Philadelphia, Pa.

Oct. 8–10: American Psychiatric Association Area 4 meeting, St. Louis, Mo.

Oct. 18–22: American College of Surgeons, annual clinical congress, Atlantic City, N. J.

Nov. 1–4: Section of Ophthalmology of Southern Medical Association, annual meeting, Houston, Tex.

Chicago Medical Society Clinical Conference

The annual clinical conference of the Chicago Medical Society is scheduled for March 1 through 4, 1965, at the Palmer House in Chicago. Designed to be of interest to all physicians, the conference is not sectionalized by medical specialties but by types of disease entities. For program or registration information, address: Clinical Conference Committee, Chicago Medical Society, 310 South Michigan Ave., Chicago, Ill. 60604.

Advanced Maternity Program, Nursing

Marquette University College of Nursing has announced that an Advanced Maternity Program in

Delivery Room Nursing will be offered this winter and spring at the College. The program runs for two weeks and the beginning dates are January 11, February 1, March 8, March 29, and May 10. Applications or anyone desiring information should direct their inquiries to Miss Anita Grand, R. N., Marquette University College of Nursing, 3029 N. 49th Street, Milwaukee, Wis. 53210.

State Medical Assistants Annual Meet

The Wisconsin State Medical Assistants Society will hold its Sixth Annual Educational Symposium on February 6 at the State Medical Society headquarters in Madison. Hostess for the meeting will be Mrs. Aleen Piepenburg, president. At 9:15 a.m. a panel discussion will be held on The Health Assistance Payment Act. Participating will be Thomas Lucas, director of the Division of Public Assistance, State Department of Public Welfare, Madison; Frank C. Zepeda, director of Accident and Health Administrative Services, Madison; William Rawley, supervisor of Wisconsin HAP claims, The Continental Casualty Co., Chicago, Ill.; Lloyd Anderson, director of Rock County Public Welfare, Janesville; and Dr. D. E. Dorchester, Sturgeon Bay.

At 11:00 a.m. Dr. Paul Mundie, psychologist, Milwaukee, will discuss Understanding the Other Person. A luncheon at noon will be followed by a tour of the State Medical Society building which houses numerous displays of medical and historical significance. The topic Communications will be discussed at 2:00 p.m. by Leonard Berry, director of education, International Consumer Credit Association, St. Louis, Mo. A group discussion will be conducted at 3:00 p.m. with dismissal at 4:00 p.m.

UW Surgery Program January 28

The Department of Surgery of the University of Wisconsin Medical School is presenting a special one-day program on "Colon and Rectal Surgery" at University Hospitals and the State Medical Society headquarters, Madison, on Thursday, January 28, 1965.

Dr. Robert Turell, U.W. alumnus now practicing surgery in New York City, will be guest speaker for the program and members of the surgical department, including Drs. Robert Hickey, Kenneth Lemmer, Robert Samp, and J. Benfield will assist. Other teachers on the program will be Dr. Frank Weston (medicine) and Dr. Sture A. M. Johnson (dermatology).

The morning program will be held at University Hospitals starting at 10 o'clock, with actual operations conducted, and viewed by closed circuit television. Following lunch at the State Medical Society, discussions will be directed to anorectal disease, diseases of the perianal area, anal fissure, fistula, hemorrhoids, prolapse, polyps, etc.

A registration fee of $5.00 includes lunch and special parking at University Hospitals for the morning program. All registrations should be directed to Roy T. Ragatz, Box 1109, Madison, Wis., with the check made payable to CES Foundation.

Other programs in the U.W. series are those on Orthopedics, Wednesday, February 17 ("Congenital Hips and Foot Deformities"); and Gynecology, Thursday, March 18 ("Endocrine Problems in Gynecology"). Registrations for these should be sent to the State Medical Society with a check to cover the fee of $5.00 per meeting.

New Orleans Graduate Medical Assembly

The 28th annual meeting of The New Orleans Graduate Medical Assembly will be held March 8–11, 1965, in New Orleans, La., with headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 55 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round table luncheons, and technical exhibits.

Details of the New Orleans meeting are available at the office of the Assembly, Room 1528, 1430 Tulane Ave., New Orleans, La. 70112.

OB "Resident's Day" at Wayne

All physicians are invited to attend Wayne State University's seventh annual "Resident's Day" in obstetrics and gynecology March 24, 1965, at the Wayne County Medical Society Building, 1010 Antietam St. at Rivard, Detroit, Mich. It is the hope of those in charge that most physicians will bring interns and residents from their hospitals.

An outstanding faculty from several universities and hospitals will present a program on such subjects as rectal versus sterile vaginal examinations in late pregnancy and during labor, clinical significance of the pathology of toxemia of pregnancy, response of infertile men and women to endocrine therapy, new concepts of sperm migration in women, community obstetrics and gynecology, what constitutes good gynecological hospital practice today, malfunctioning ovaries, and prevention of maternal death from hemorrhage.

A special feature will be the opportunity for physicians to send any biopsies of the endometrium, ovary or testis they may have from an infertile patient in for a free opinion. A panel at the morning session will discuss the endometrium, ovary and testis in infertile individuals, and the material sent in may be used in the panel. The microscopic slides and a history on the case should be sent not later than mid-February to Dr. Charles S. Stevenson of the Department of Obstetrics and Gynecology, Wayne State University School of Medicine, one of the panelists. All inquiries may also be addressed to Doctor Stevenson at the University at 1500 Chrysler Expressway, Detroit 7, Mich. There is no registration fee for the meeting, but advance registration by mail is requested. Advance purchase of meal tickets by mail is recommended. Luncheon tickets will cost $1.50 and the dinner ticket, $5.00.

Effective against pathogens encountered daily...or rarely

Consistently reliable against common bacterial infections, Terramycin (oxytetracycline) meets the acid test of broad-spectrum effectiveness by scoring high in activity against many recalcitrant and less frequently encountered organisms as well. *Balantidium, Leptospira, Pseudomonas, Listeria, Shigella,* the vibrios—all are responsible for difficult-to-treat infections and many strains are susceptible to oxytetracycline.

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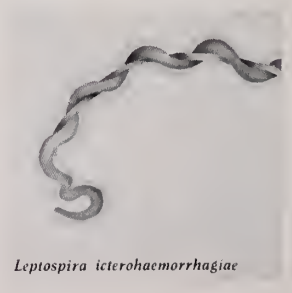

Leptospira icterohaemorrhagiae

New Wisconsin Laws of 1963

AFTER A RECESS which began August 6 the Legislature returned on November 4, 1963. The two Houses have approximately 500 bills pending and an unlimited amount of new legislation is already being offered. In addition, the Houses will have to consider bills vetoed by the Governor, and the Senate has a large number of appointments pending before it. It is thus impossible to estimate how long the session will continue.

The greater number of bills of special interest to the medical profession is still pending, but some have already been enacted into law. Because of their importance, and in most cases their brevity, it seemed better to reproduce certain of the new laws in full rather than to describe them in detail.

Laws newly enacted during the 1963 session include the following chapters which should be of special interest to the medical profession:

1. Chapter 94 is of the type generally described as a "Good Samaritan Law." This act relieves licensed physicians and registered nurses from liability for civil damages as a result of the acts or omissions of a member of either profession in rendering emergency care at the scene of an emergency. The "scene of an emergency" does not include the confines of an institution which has hospital facilities, or a physician's office.
2. Chapter 224. Section 110 of the budget and tax act contains the Wisconsin implementation of the Kerr–Mills Act. We have excerpted only those portions for your reading. The Legislature entitled this new chapter of the statutes "The Health Assistance Payments Act."
3. Chapter 325 is entitled the "Radiation Protection Act." The State Board of Health and the Industrial Commission are to be the state agencies in charge of protecting against overexposure to ionizing radiation. The Board of Health has authority over units used by physicians, dentists and others in the course of their practice. The Act calls for annual registration of each machine used in private practice, including those of an office, clinic, hospital or other health institution.
4. Chapter 328 raises the amount of nondeductible medical expense from the present $75 to $85, but increases the maximum deduction for such expenses from $1,500 to $2,500. This will extend substantial relief to those families which incur heavy medical expenses in a given year. As in the past, health expenses will be deductible from gross income.
5. Chapter 339 has been called the "Battered Child Syndrome." The act provides that where the examination of an abused or injured minor creates a reasonable ground for an opinion of the physician that the condition was intentionally caused or inflicted by another, and the minor is unable or unwilling to disclose the facts or the name of such other person, such situation is made an express exception to the privileged communication section of the statutes.

   Having created such exception, the act then establishes a duty in such examining physician to report the facts and circumstances, and his opinion to the district attorney or sheriff of the county in which such injuries are believed to have been inflicted.

Physicians are urged to read the attached Acts with care. They are representative of various types of health legislation, or of laws at least indirectly related to the subject.

STATE OF WISCONSIN

No. 88, A. Published June 10, 1963

CHAPTER 94, LAWS OF 1963

AN ACT

AN ACT to create 147.17 (7) and 149.06 (5) of the statutes, relating to exempting doctors and nurses from civil liability for emergency treatment at the scene of the emergency.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 147.17 (7) of the statutes is created to read:

147.17 (7) No person licensed under this section, who in good faith renders emergency care at the scene of an emergency, is liable for any civil damages as a result of acts or omissions by such person in rendering the emergency care.

For the purpose of this subsection, the scene of an emergency shall be those areas not within the confines of a hospital or other institution which has hospital facilities, or a physician's office.

SECTION 2. 149.06 (5) of the statutes is created to read:

149.06 (5) No person registered under this section, who in good faith renders emergency care at the scene of an emergency, is liable for any civil

damages as a result of acts or omissions by such person in rendering the emergency care.

For the purpose of this subsection, the scene of an emergency shall be those areas not within the confines of a hospital or other institution which has hospital facilities, or a physician's office.

* * *

CHAPTER 224, LAWS OF 1963

(Section 110 excerpted from the budget and tax act)

SECTION 110. Chapter 163 of the statutes is created to read:

CHAPTER 163
HEALTH ASSISTANCE PAYMENTS

163.01 TITLE. This chapter shall be known as: "The Health Assistance Payments Act."

163.02 PURPOSE. This chapter recognizes that unusual and unanticipated illness or accident, sometimes requiring health care over a long period of time, has an impact upon the income and resources of the elderly beyond and different from that experienced by those in younger age categories. It provides that where such costs present a financial hardship which might impoverish the elderly, or require liquidation of home and other assets, the public, through general taxation, should join in a cooperative effort to alleviate such problems. It is the intent to encourage the sense of family responsibility which has always been a bulwark of American life. It is the further intent that the public, through general taxation, supply all or most of the funds required to insure, as far as practicable, the health needs of this important segment of the population through contracts between the state and one or more of the nonprofit organizations incorporated or existing under or by virtue of ss. 148.03, 152.53, and 182.032, or one or more insurance companies licensed to do business in this state. It is also the intent to help keep as many older citizens as possible on a self-sustaining basis by protecting them against major health costs.

163.03 DEFINITIONS. As used in this chapter, unless the context indicates otherwise:

(1) "Beneficiary" means a person eligible for, and a recipient of, assistance under this chapter.

(2) "Charge" means the customary, usual and reasonable demand for payment for services, care or commodities which does not exceed the general level of charges by others who render such services or care, or provide such commodities, under similar or comparable circumstances within the community in which the charge is incurred.

(3) "Department" means the state department of public welfare.

(4) "Hospital" means an institution providing 24-hour continuous nursing service to patients confined therein; which provides standard dietary, nursing, diagnostic and therapeutic facilities; and whose professional staff is composed only of physicians and surgeons, or of physicians and surgeons and doctors of dental surgery.

(5) "Illness" means a bodily disorder, bodily injury, disease or mental disease. All illnesses existing simultaneously which are due to the same or related causes shall be considered "one illness." Successive periods of illness less than 6 months apart, which are due to the same or related causes, shall also be considered "one illness."

(6) "Income" means adjusted gross income reportable annually for federal income tax purposes; except that for the purposes of this chapter it includes social security benefits, alimony, gross amount of any pension, annuity or other retirement income, however denominated.

(7) "Mental disease" means any condition classified as a neurosis, psychoneurosis, psychopathy or psychosis.

(8) "Personal assets" means a home and the land used and operated in connection therewith, or a mobile home used as a place of abode; household and personal possessions, including an automobile; and additional property not in excess of $5,500 in value, if single, or $9,000, if married, in any combination of real property, tangible personal property, cash value of life insurance, or cash or other liquid assets.

(9) "Physician" means a person licensed to practice medicine and surgery, and includes graduates of osteopathic colleges holding an unlimited license to practice medicine and surgery.

(10) "Prescribed" means a written order or an oral order later reduced to writing by a licensed physician or dentist for a product or service.

(11) "Skilled nursing home" means a facility, licensed or approved as such by the state board of health or other state agency having jurisdiction over it, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care and which employs sufficient registered nursing practitioners for supervision of those giving nursing care to patients.

(12) "Spouse" means the legal husband or wife of the beneficiary, whether or not eligible for benefits under this chapter.

(13) "Visiting nurse" means a registered nurse or a trained practical nurse employed by an organized, voluntary home nursing agency or by an official agency established under s. 141.10, and rendering home nursing services to patients who are under the care of a physician.

163.04 ELIGIBILITY. (1) Any resident of this state is eligible for benefits under this chapter who shows by a sworn statement on a form prescribed by the department that he:

(a) Has attained the age of 65; and

(b) Is a citizen or has filed a declaration to become one; and

(c) Is not receiving old-age assistance; and

(d) Does not have personal assets in excess of the amounts specified in s. 163.03 (8), and that his annual income does not exceed $1,800, if single, or $2,700, if married; except that any applicant shall be eligible when he has expended all of his income in excess of the above applicable limits for health services of the type available under this chapter, or for personal health insurance premiums, or both; and

(e) Has not, within one year of the date of making application hereunder, conveyed, transferred or disposed of property so as to make himself eligible for benefits under this chapter.

(2) The department may make additional investigation of eligibility when there is reasonable ground for belief that an applicant may not be eligible, or that a beneficiary may have received benefits hereunder to which he was not entitled, or upon the request of the secretary of the U. S. department of health, education and welfare.

(3) Persons eligible as beneficiaries shall not be denied the benefits of this chapter because of absence from the state.

(4) At any time that he believes himself eligible under this chapter any person may file an application with the department requesting a determination of his eligibility. Eligibility may be determined before the need for services arises and reapplication at the time of illness is not necessary. Every applicant shall receive notification in writing promptly as to the action taken on his application. Such notification, if approving eligibility, shall specify the period of eligibility.

163.05 BENEFITS; EXCLUSIONS. (1) The department shall determine the maximum allowances of a health plan to be administered to s. 163.06, which, subject to applicable deductible coinsurance and other provisions established by it, shall pay part or all of the charges to beneficiaries for the following: inpatient hospital care in a semiprivate room; skilled nursing home care when authorized by a physician; professional services performed by a physician or doctor of dental surgery in a hospital or skilled nursing home; outpatient services provided through a hospital or by a physician in a hospital; and the following additional services when prescribed by a physician: care by a visiting nurse, diagnostic services which require X-ray or laboratory procedures and pharmaceutical services.

(2) Benefits shall not include any payments with respect to:

(a) Care or services for any individual who is an inmate of a public institution, except as a patient in a medical institution, or any individual who is a patient in an institution for tuberculosis or mental disease; or

(b) Care or services for any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or mental disease, with respect to any period after the individual has been a patient in such an institution, as a result of such diagnosis, for 42 days; or

(c) Care or services in any other private or public institution unless it has been approved by a standard-setting authority responsible by law for establishing and maintaining standards for such institution; or

(d) That part of any services otherwise authorized under this section which are payable through insurance, third party liability, or any federal, state, county, municipal or private benefit systems to which the beneficiary may otherwise be entitled.

(3) Payments made under this section shall be subject to the following limitations:

(a) An applicant must first expend 5 per cent of his annual allowable income for the health services provided in this section;

(b) Expenses of skilled nursing home care will be paid only for beneficiaries transferring directly to such facility from a hospital; and

(c) The maximum combined liability for payment for care in a hospital and skilled nursing home under this section shall be 45 days per illness.

(4) Payments shall not include care or services rendered earlier than the month preceding the month of the application, but in no event may payments be made for health services rendered during a period when the beneficiary would not have been eligible for benefits under this chapter.

(5) Payment for services provided by a plan established under this section shall be made directly to the hospital, skilled nursing home, other organization or individual providing such services pursuant to the provisions of any contract that may be entered into under s. 163.06.

(6) No source of service may bill the beneficiary of a plan established hereunder, except for or to the extent that benefits are not provided by it.

(7) If the funds appropriated become or are estimated to be insufficient to make full payment of benefits provided by a plan established under this section, all charges for services so authorized shall be prorated on the basis of the funds available, or by limiting the benefits provided.

163.06 ADMINISTRATION OF PLAN. The department shall prompty solicit bids from nonprofit organizations incorporated or existing under and by virtue of the provisions of s. 148.03 or 182.032, and from insurance companies licensed and authorized to do business in this state, to administer, for and on behalf of the state, the benefits provided for under s. 163.05. The department shall award the contract for such services to the lowest qualified bidder.

163.07 ADMINISTRATION, GENERAL. (1) The department shall exercise responsibility relating to fiscal matters, the eligibility of beneficiaries under the standards set forth in s. 163.04, and general supervision of the plan established under s. 163.05 (1). The state board of health shall serve in an advisory capacity in the health care as distinguished from the administrative aspects of such a plan.

(2) The department shall employ necessary personnel within the limitations of the sums appropriated by s. 20.670 (27), and under the classified service, for the efficient and economical performance of duties imposed by this section, and shall supply residents of this state with information concerning this program and procedures to be followed by an applicant believing himself eligible for assistance under this section.

(3) The department may audit all claims filed under s. 163.05 and make proper fiscal adjustments.

(4) No contractor under s. 163.06 shall be obligated to make any payment until the claimant has been certified by the department as a beneficiary. Such certification shall be accepted by the contractor as conclusive of its accuracy. The department shall reimburse the contractor for payments made mistakenly on the basis of an incorrect certification.

(5) The state shall reimburse the county in full for allowable expenditures incurred pursuant to departmental rules in exercising functions in connection with this chapter delegated to the county agency by the department.

(6) The department may delegate to the county welfare agency in each county duties and functions to be performed in assisting the state in administration of this section, and the agency shall perform such duties and functions and shall file with the department all forms and reports as required. Any personnel in the county agency performing duties under this subsection shall be employed pursuant to the merit system.

(7) The department shall certify all proper charges, or claims for administrative services, to the department of administration for payment, and the department of administration shall draw its warrant forthwith.

163.08 APPEAL. Any person whose application is denied or is not acted upon promptly or who believes that the payments made in his behalf have not been properly determined may file an appeal with the department pursuant to s. 49.50 (8).

163.09 RECOVERY OF PAYMENT. (1) On the death of a person who has received medical assistance under this chapter, and his surviving spouse, the total amount of such assistance paid shall be filed by the department as a claim against his estate, but such claim shall not take precedence over the allowances under s. 313.15, or over any other claim for care or maintenance furnished by the state or its political subdivisions. The court may provide for the maintenance or support of a surviving minor or incapacitated adult children, and thereupon the claim shall be waived to the extent of the amount disallowed and that amount assigned to such children for maintenance or support.

(2) For benefits incorrectly paid recovery shall be made before the death of the recipient pursuant to the judgment of a court of record.

(3) All amounts received pursuant to this section shall be deposited in the state treasury, and out of the net amount recovered the federal government shall be paid the proportionate amount which it contributed.

163.10 INFORMATION RESTRICTED. The use or disclosure of any information concerning applicants and recipients for any purpose not connected with the administration of this section is prohibited.

163.11 RULE-MAKING POWERS. The department is authorized to make such rules as are consistent with its duties under this chapter, and shall be empowered to co-operate with the federal government in carrying out the purposes of Title VI, P.L. 86–778.

163.12 FREE CHOICE. Nothing contained in this chapter shall alter the right of each eligible person to the free choice of physician, dentist, pharmacist, hospital or skilled nursing home. The legal responsibility of physician or dentist to patients and all other contract and tort relationships with patients shall remain as though dealings were direct between such physician or dentist and patient. No physician or dentist shall be required to practice exclusively in any plan established under this chapter.

163.13 PENALTY. Any person who receives or assists another in receiving assistance under the chapter, to which he is not entitled, shall be subject to the penalties provided in s. 49.12.

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STATE OF WISCONSIN

No. 444, S. Published Sept. 24, 1963

CHAPTER 325, LAWS OF 1963

AN ACT

AN ACT to repeal 20.440 (44) and 101.50; and to create 20.410 (52) and 140.50 to 140.60 of the statutes, relating to radiation protection, prescribing powers and duties of the industrial commission and the state board of health, providing for registration of radiation sources, creating an advisory radiation protection council, providing penalties, granting rule-making authority and making an appropriation.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.410 (52) of the statutes is created to read:

20.410 (52) RADIATION PROTECTION ACT. All moneys collected under s. 140.54 shall be paid within one week into the general fund, as a revolving appropriation, and are appropriated therefrom to the state board of health for the administration of ss. 140.50 to 140.60.

SECTION 2. 20.440 (44) of the statutes is repealed.

SECTION 3. 101.50 of the statutes is repealed.

SECTION 4. 140.50 to 140.60 of the statutes are created to read:

140.50 NAME OF THE ACT. Sections 140.50 to 140.60 shall be known as the radiation protection act.

140.51 PUBLIC POLICY. Since ionizing radiations and their sources can be instrumental in the improvement of the health and welfare of the public if properly utilized, and may be destructive or detrimental to life or health if carelessly or excessively employed or may detrimentally affect the environment of the state if improperly utilized, it is hereby declared to be the public policy of this state to encourage the constructive uses of radiation and to prohibit and prevent exposure to ionizing radiation in amounts which are or may be detrimental to health. It is further the policy to advise, consult and co-operate with the industrial commission and other agencies of the state, the federal government, other states and interstate agencies and with affected groups, political subdivisions and industries; and, in general, to conform as nearly as possible to nationally accepted standards in the promulgation and enforcement of rules.

140.52 DEFINITIONS. As used in ss. 140.50 to 140.60. (1) "Board" means the state board of health.

(2) "Commission" means the industrial commission.

(3) "By-product material" means any radioactive material (except special nuclear material) yielded in or made radioactive by exposure to the radiation incident to the process of producing or utilizing special nuclear material.

(4) "Nuclear facility" means any reactor plant, any equipment or device used for the separation of the isotopes of uranium or plutonium, the processing or utilizing of radioactive material or handling, processing or packaging waste; any premise, structure, excavation or place of storage or disposition of waste or by-product material; or any equipment used for or in connection with the transportation of such material.

(5) "Radiation" or "ionizing radiation" as used in this chapter refers to electromagnetic radiations such as X rays and gamma rays, or particulate radiations such as electrons or beta particles, protons, neutrons, alpha particles, usually of high energy, but in any case it includes all radiations capable of producing ions directly or indirectly in their passage through matter.

(6) "Radiation installation" is any location or facility where radiation machines are used or where radioactive material is produced, transported, stored, disposed of or used for any purpose.

(7) "Radiation machine" is any device that produces radiation when in use.

(8) "Radioactive material" includes any solid, liquid or gaseous substance which emits radiation spontaneously.

(9) "Radiation source" means a radiation machine or radioactive material as defined herein.

(10) "Source material" means any material except special nuclear material, which contains by weight 0.05 per cent or more of uranium, thorium, or any combination thereof.

(11) "Special nuclear material" means plutonium, uranium 233, uranium enriched in the isotope 233 or in the isotope 235, and any other material which the atomic energy commission determines to be special nuclear material; or any material artificially enriched by any of the foregoing. Special nuclear material does not include source material.

140.53 POWERS AND DUTIES. (1) The board and the commission shall:

(a) Formulate, adopt and enforce, amend and repeal rules, including registration of sources of radiation, as may be necessary to prohibit and prevent unnecessary radiation. Such rules may incorporate by reference the recommended standards of nationally recognized bodies in the field of radiation protection and other fields of atomic energy, under the procedure established by s. 227.025.

(b) Administer ss. 140.50 to 140.60 and the rules promulgated thereunder.

(c) Develop comprehensive policies and programs for the evaluation and determination of hazards associated with the use of radiation, and for their amelioration.

(d) Advise, consult and co-operate with other agencies of the state, the federal government, other states and interstate agencies, and with affected groups, political subdivisions and industries.

(e) Encourage, participate in or conduct studies, investigations, training, research and demonstrations relating to the control of radiation hazards, the

measurement of radiation, the effects on health of exposure to radiation and related problems as it deems necessary or advisable for the discharge of its duties under ss. 140.50 to 140.60.

(f) Collect and disseminate health education information relating to radiation protection as it deems proper.

(g) Review and approve plans and specifications for radiation sources submitted pursuant to rules promulgated under ss. 140.50 to 140.60; and inspect radiation sources, their shielding and immediate surroundings and records concerning their operation for the determination of any possible radiation hazard.

(2) The board and the commission may:

(a) Enter, at all reasonable times, any private or public property for the purpose of investigating conditions relating to radiation control.

(b) Accept and utilize grants or other funds or gifts from the federal government and from other sources, public or private, for carrying out its functions under ss. 140.50 to 140.60. Such studies, investigations, training and demonstration may be conducted independently, by contract, or in cooperation with any person or any public or private agency, including any political subdivision of the state.

140.54 REGISTRATION. (1) APPLICATION. Every radiation installation in this state, not exempted by this section or the rules of the board or this section shall be registered by the board by January 1, 1964, by the person in control thereof, and no such radiation installation shall be operated thereafter unless it has been duly registered by January 1 of each year and a notice of such registration is possessed by the person in control. Every radiation installation established in this state after January 1, 1964, shall be registered prior to its operation. The application for registration shall be made on forms provided by the board which shall be devised to obtain any information that is considered necessary for evaluation of hazards. Multiple radiation sources at a single radiation installation and under the control of one person shall be listed on a single registration form and only one registration fee shall be required. Registration alone shall not imply approval of manufacture, storage, use, handling, operation or disposal of the radiation installation or radioactive materials, but shall serve merely to inform the board of the location and character of radiation sources. The board shall furnish the commission with a copy of each amended and new registration. Persons engaged in manufacturing, demonstration, sale, testing or repair of radiation sources shall not be required to list such sources on the registration form.

(2) AMENDED REGISTRATION. Whenever the person in control increases the number of sources, source strength, rated output or energy of radiation produced in any installation, he shall notify the board of such increase prior to operation on such revised basis, and such change shall be recorded in the registration. If any installation is discontinued, the person in control shall notify the board within 30 days of such discontinuance.

(3) FEES. An annual registration fee of $5 shall be levied on every person in control of a radiation installation registering under this section. No additional fee shall be required for recording changes in the registration information.

(4) EXEMPTIONS. The board shall exempt from registration any source licensed by the atomic energy commission and may exempt from registration any source of radiation installation which the board finds to be without undue radiation hazard as determined by standards established by the national committee on radiation protection and measurements or any comparable nationally recognized agency established for the purpose of recommending standards for radiation protection, and after the initial registration may exempt from subsequent annual registration requirements any source of radiation devoted primarily to industrial purposes.

140.56 ADVISORY RADIATION PROTECTION COUNCIL. (1) There is created an advisory radiation protection council to advise and consult in carrying out the administration of ss. 140.50 to 140.60 and in the development of rules. It shall provide the board with technical advice and assistance.

(2) The advisory radiation protection council shall consist of 9 members, 5 to be appointed by the board and 4 by the commission.

(3) The terms of office of all members of the advisory council shall be 3 years, except that in making the original appointments of the 5 members appointed by the board one shall be appointed to serve for terms of 1 year, 2 for 2 years and 2 for 3 years. Of the 4 members appointed by the commission 2 shall be for 1 year, 1 for 2 years, and 1 for 3 years. All members shall serve after the expiration of their terms until their respective successors are appointed and qualified. Any vacancy occurring, whether by expiration of the term or otherwise, shall be filled by the appointing authority for the unexpired term.

(4) The chairman of the advisory council shall be elected by the members from among their membership. Five members of the advisory council shall constitute a quorum to transact its business.

(5) The advisory council shall meet as frequently as necessary but not less than once each year. Meetings shall be called by the chairman upon request of the board or 5 members of the advisory council.

(6) All members of the advisory council shall serve without compensation but shall be entitled to receive their actual and necessary expenses while serving as a council member.

140.57 UNIFORM CODE. The board shall, on the recommendation of the advisory council promulgate a radiation protection code. Other departments and agencies of state government and local governmental units may adopt the identical code, but no other codes or ordinances relating to this subject shall be promulgated or enacted.

140.58 ENFORCEMENT. (1) NOTIFICATION OF VIOLATION AND ORDER OF ABATEMENT. Whenever the board or commission finds, upon inspection and examination, that a source of radiation as constructed, operated or maintained results in a violation of ss. 140.50 to 140.60 or of any rules promulgated thereunder, it shall notify the person in control that is causing, allowing or permitting such violation as to the nature thereof and order that, prior to a specified time such person in control shall cease and abate causing, allowing or permitting such violation and take such action as may be necessary to have the source of radiation constructed, operated, or maintained in compliance with ss. 140.50 to 140.60 and rules promulgated thereunder.

(2) The board or commission shall issue and enforce such orders or modifications of previously issued orders as may be required in connection with proceedings under ss. 140.50 to 140.60. Such orders shall be subject to review by the board upon petition of the persons affected. Whenever the board or commission finds that a condition exists which constitutes an immediate threat to health due to violation of ss. 140.50 to 140.60 or any rule or order promulgated thereunder it may issue an order reciting the existence of such threat and the findings pertaining thereto. The board or commission may summarily cause the abatement of such violation.

(3) The state board of health shall enforce the rules pertaining to ionizing radiation in establish-

ments principally engaged in furnishing medical, surgical, chiropractic and other health services to persons and animals. The industrial commission shall enforce the rules pertaining to ionizing radiation in industrial establishments. The board shall notify the commission and deliver to it a copy of each new registration and at such time a decision shall be made as to which state agency shall enforce the rules pertaining to ionizing radiation. The board and the commission are directed to consult with the advisory committee in case of jurisdictional problems.

(4) All orders issued pursuant to ss. 140.50 to 140.60 shall be enforced by the attorney general. The circuit court of Dane county shall have jurisdiction to enforce such orders by injunctional and other appropriate relief.

140.59 IMPOUNDING MATERIALS. The board or commission may impound or order the sequestration of sources of ionizing radiation in the possession of any person who is not equipped to observe or who fails to observe such safety standards to protect health as may have been established by rule.

140.595 EXCEPTIONS. (1) Nothing in ss. 140.50 to 140.60 shall be interpreted as limiting intentional exposure of persons to radiation for the purpose of analysis, diagnosis, therapy, and medical, chiropractic or dental research as authorized by law.

(2) Sections 140.50 to 140.60 shall not apply to on site activities of any nuclear reactor plant licensed or operated by the atomic energy commission.

140.60 PENALTIES. Any person who violates any provision of ss. 140.50 to 140.60 or any rule or order of the board or commission issued pursuant thereto shall forfeit and pay into the state treasury not less than $10 nor more than $500. Each day of continued violation after notice of the fact that a violation is being committed shall be considered a separate offense. Should injury or death of an employe ensue, due to a failure of an employer to observe or enforce any rule issued under ss. 140.50 to 140.60, compensation and death benefits shall be increased by 15 per cent as provided in s. 102.57.

SECTION 5. TRANSITION PROVISIONS. On July 1, 1963, all of the functions relating to the registration of sources of ionizing radiation are transferred from the industrial commission to the state board of health, and all matters relating thereto pending before the commission shall be completed by the board. No employes shall be removed because of this transfer. All nonlapsed unencumbered balances in the appropriation of the industrial commission attributable to this function are transferred to the board of health.

SECTION 6. This bill is declared to be an emergency appropriation bill, in accordance with the requirements of section 16.47 (2) of the statutes.

* * *

[Corrected Copy]

STATE OF WISCONSIN

No. 150, A. Published Sept. 26, 1963; Re-published Oct. 16, 1963

CHAPTER 328, LAWS OF 1963

AN ACT

AN ACT to amend 71.05 (9) of the statutes, relating to deductions from income for medical expenses.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 71.05 (9) of the statutes is amended to read:

71.05 (9) With respect to determination of net taxable income for the calendar year * * * *1963* and corresponding fiscal years, and thereafter, expenses paid during the income year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or of a dependent specified in s. 71.09 (6) (b) (regardless of the gross income of such dependent) in excess of *$85* but not more than * * * *$2,500.* Expenses paid for medical care under this subsection shall include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance).

SECTION 2. This bill is declared to be an emergency appropriation bill in accordance with section 16.47 (2) of the statutes.

* * *

STATE OF WISCONSIN

No. 457, S. Published Sept. 27, 1963

CHAPTER 339, LAWS OF 1963

AN ACT

AN ACT to renumber and amend 325.21; and to create 325.21 (2) of the statutes, relating to physicians or surgeons disclosing information of suspicious childrens injuries to a criminal law enforcement official or agency.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 325.21 of the statutes is renumbered 325.21 (1) and amended to read:

325.21 (1) No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only:

* * * *(a)* In trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide,

* * * *(b)* In all lunacy inquiries,

* * * *(c)* In actions, civil or criminal, against the physician for malpractice,

* * * *(d)* With the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition,

* * * *(e)* In situations where a hospitalized person is adjudicated either mentally ill, mentally infirm or mentally deficient or is a voluntary mental patient in either a public or private institution and the release of medical information is necessary so that the person can qualify for either an insurance benefit or some type of federal, state or county benefit or pension for either himself or his dependents,

(f) In situations where the examination of an abused or injured minor creates a reasonable ground for an opinion of the physician or surgeon that the condition was intentionally caused or inflicted by another and the child is unable or unwilling to disclose the facts and circumstances and the name of such another.

SECTION 2. 325.21 (2) of the statutes is created to read:

325.21 (2) A physician or surgeon being of the opinion as specified in sub. (1) (f) shall report the same and the facts and circumstances forming the opinion to the district attorney or sheriff of the county.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which is reprinted in full beginning with page 10 hereof.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

Patients generally are classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has 3 years within which to sue for personal injuries. If a patient elects to sue on a contract rather than for alleged negligence, he has 6 years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there are doubtless sound professional reasons for retaining them longer.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

It should be mentioned here that an accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill. The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

The allegation that something is missing from the record could be of great importance when the patient is suing a physician or hospital. Since the patient does have a right of access to the use of relevant records which concern his care and treatment, it would appear to be advisable to keep the originals for at least the 6 year period.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959, which follows. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, model forms are not recommended. Sample forms are included in the *Interpretation* which follows but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

An Interpretation of Chapter 301; Laws of 1959

(Prepared jointly by The State Medical Society of Wisconsin and the Wisconsin Hospital Association)

1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that

the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and that the originals of the records cannot be taken out of their custody at any time *except* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by non-medical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which

NOTE

Chapter 301, Laws of 1959, as passed by the 1959 Wisconsin Legislature and signed by the Governor, created the following subsections to Section 269.57, Wisconsin Statutes, 1961:

269.57 (3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

The 1961 session of the legislature enacted the following new subsection to Section 269.57, Wisconsin Statutes:

"269.57 (5) The provisions of sub. (4) shall not be applicable to state or county mental hospitals, or to state colony and training schools, or to community mental health clinics established pursuant to s. 51.36."

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____19____ to
(State name of patient or "myself")

_____19_____ or to allow those records to be inspected or copied by_____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from_____19____ to
(State name of patient or "myself")

_____19_____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators, physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

Legal Responsibilities of the Physician-Patient-Hospital Relationship

THREE SPECIFIC questions pertaining to the physician-patient-hospital relationship were recently submitted to the Society's legal counsel by the Commission on Hospital Relations and Medical Education for an opinion. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The only statutes on hospitals relate to construction, safety, standards of maternity departments, and in the case of the Fee Splitting Statute forbid a hospital to employ a physician or to engage in a fee splitting arrangement with him.

In general terms, the courts have held that a physician has a legal responsibility to his hospitalized patient to furnish that degree of professional skill which is the standard of the medical community, and to give such professional attention to the patient as the case requires. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient no longer needs his professional services, and he may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts increasingly tend to distinguish the *administrative* negligence of a hospital from the *professional* or *medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital is liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

It is also possible that both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to

determine during the course of the trial that no liability exists against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility*. It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

It is therefore neither necessary nor advisable to try to generalize a joint responsibility since it is seldom present in fact.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted*, so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

In my judgment increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining", and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment.

While we find no Wisconsin cases on the point, a physician undoubtedly could, as we earlier indicated, enforce a right of contribution against the hospital in a situation in which he had been held liable and a judgment enforced against him, although the liability was partially that of the hospital.

* * *

It should be noted that the extent of legal liability of all but government hospitals is not clear at the moment in this state because the Supreme Court of

Wisconsin did not abolish the long established tort immunity rule until January, 1961, and there has not been opportunity as yet for the development of new court law in light of such abolition. It should be noted that the old rule of tort immunity still applies in government hospitals which are therefore not subject to suit for the alleged negligence of their employees.

Many points have not been covered in this opinion because they did not seem closely enough related to the questions. Thus, there has been no discussion of the contractual relationship between patient and physician. Rather it has been assumed to exist for purposes of answering the questions. No questions of adequacy of patient consent, either from the standpoint of physician or hospital, have been touched upon. It has been assumed also that hospital records were adequately maintained by the physician and by the non-medical staff under his direction, and that in other respects not specified the hospital and its employees were functioning properly and the physician was acting within the limits of the standard of professional care owed the patient.

SAVE YOUR "BLUE BOOK" ISSUE FOR FUTURE REFERENCE

This January "Blue Book" issue of the *Wisconsin Medical Journal* contains a variety of articles relating to medicolegal matters of direct concern to the physician in his relationship to governmental agencies. An annual presentation since 1924, the edition is unique among medical journals of the United States. Each one has been an outstanding legal service to members of the Society. A permanent file of these issues for future reference is recommended.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. **Find Your Future in the Health Field**
   A career guide (the health careers brochure).

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **School Health Examinations**
    A guide for physicians and school authorities in establishing a program of school health examinations.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **First Aid Chart**

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Medical Staff Rules and Regulations as to Sterilizations

THE STERILIZATION of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

Section 46.12, Wisconsin Statutes, 1961:

"46.12 Sterilization of defectives

(1) The department [of public welfare] may appoint a surgeon and a psychiatrist of recognized ability, as experts, who (in conjunction with the superintendents of the state and county institutions who have charge of criminal, mentally ill and mentally deficient persons) shall examine inmates and patients of such institutions as to their mental and physical condition.

(2) The department may submit to the experts and to the superintendent the name of inmates or patients they desire examined, and the experts and the superintendent shall meet, take evidence and examine into the mental and physical condition of the named inmates or patients and report thereon to the department.

(3) If the experts and superintendent unanimously find that procreation is inadvisable the department may authorize an operation for the prevention of procreation.

(4) Before such operation, the department shall give at least 30 days' notice in writing to the husband or wife, parent or guardian of the inmate or patient, if known, and if unknown, to the person with whom such inmate or patient last resided.

(5) The experts shall receive as compensation $10 per day and expenses for the days consumed in the performance of their duties.

(6) The record made upon the examination shall be filed in the department; and semi-annually after the operation, the superintendent of the institution where such inmate or patient is confined shall report to the department his condition.

(7) The department shall state in its biennial report the number of operations performed under this section and the result of the operations."

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

The following opinion, furnished by legal counsel for the State Medical Society, was provided in answer to an inquiry from a hospital chief of staff and relates to the adoption of medical staff rules and regulations concerning surgery for the sterilization of patients. In substance, however, the opinion covers the law on this subject generally.

* * *

The only Wisconsin statute which specifically relates to the procedure to be followed in sterilization cases relates to criminals, the mentally ill and mentally deficient who are in state or county institutions. A copy of that statute, which is Section 46.12, is printed herein in full because it indicates the safeguards with which the Legislature surrounded the sterilization of individuals who are not able to live in a normal way in society. It seems reasonable to anticipate that if the Legislature were to enact legislation covering sterilization in noninstitutional cases, it would provide at least as careful safeguards for the "normal" majority of the public.

No court decisions have been found in Wisconsin passing on the legal aspects of the sterilization either of institutional or noninstitutional patients. The Attorney General of Wisconsin has ruled on the subject several times, however. In 1932, an Opinion was published, holding, in substance, that even if an institutionalized person were sterilized under all of the safeguards of Section 46.12 of the Wisconsin Statutes, above referred to, there was a serious question, except where the procedure was strictly therapeutic, whether the public officials who requested such surgery and the surgeon who performed the operation were not criminally liable for the common law offense of mayhem, or bodily mutilation.[1]

The Attorney General had ruled four years earlier that an incompetent person could not be legally sterilized except under Section 46.12.[2] The later opinion cited above would thus appear to be an even stricter view.

In 1938, another Opinion of the Attorney General was rendered to the effect that a vasectomy on a person who was not within one of the categories enumerated in Section 46.12 of the Statutes (in other words not in an institution for criminals, the mentally ill or mentally deficient) probably would not

subject the surgeon to criminal liability under the mayhem statute if the surgery was performed to benefit the health of the patient. Attention is invited to the careful wording of the final paragraph of the Attorney General's Opinion which stated:

> "We conclude that vasectomy in the instant case *may* be excusable by reason of necessity to preserve health."[3] (Emphasis added.)

It seems clear that a fair reading of the Attorney General's Opinions justifies the conclusion that the Attorney General of this state has taken a consistently conservative attitude toward sterilization surgery whether performed on certain types of institutionalized patients, such as the mentally deficient, or upon normal persons in the ordinary course of private medical practice.

The performance of sterilization surgery for any but clearly therapeutic reasons could subject the surgeon to criminal penalties and to civil liability for damages on suit either of the patient, spouse, parent, or guardian. Mayhem, or bodily mutilation, is a criminal offense under Section 940.21 of the Wisconsin Criminal Code, and is punishable by a fine up to $5,000, imprisonment up to 15 years, or both.

Rules and regulations on this subject should specify the number of consultants in sterilization cases and specify clinical indication for such operation.

It is recommended that at least two physicians be called into consultation before sterilization surgery is performed. That is the number required by Section 46.12 for institutional cases. Under provisions of Rule 14, of the Joint Commission on Accreditation of Hospitals, such a consultant must be well qualified to give an opinion, and a satisfactory consultation would include examination of the patient and his record and a written opinion signed by the consultant and recorded prior to the surgery, except in emergencies. Finally, the same model rule provides that to the extent possible, consultation by physicians associated in the same office should be avoided so as to reduce the likelihood of an assertion that one associate was backing up the other.

As to the enumeration of the clinical indication for such operations for sterilization, this is a matter for determination by the medical staff. An obvious example would be cancer of the reproductive system of a male or female, or the existence of venereal disease in an advanced stage. Additional examples could undoubtedly be procured from medical authorities.

REFERENCES

1. 21 O.A.G. (1932) 940.
2. 17 O.A.G. (1928) 524.
3. 27 O.A.G. (1938) 416.

Nontherapeutic Vasectomy

THE STATE Medical Society recently received the following inquiry from a hospital medical staff:

> **What are the legal implications involved if a vasectomy is considered necessary to safeguard the health of a man's wife? (In other words, if a woman for sound medical reasons should not be subjected to further childbirth, but is not physically able to withstand a surgical procedure, is it legally acceptable for the husband to subject himself to a vasectomy procedure?)**

The question was referred to legal counsel for the State Medical Society. Their opinion is as follows:

> According to our understanding the gist of your question is whether it is lawful for a physician to perform a vasectomy in Wisconsin on a male in the absence of therapeutic reasons insofar as the patient himself is concerned.

In our judgment, under present Wisconsin law, the surgeon who performed the vasectomy under the facts assumed above would subject himself to criminal and civil liability as set forth in the article above referred to. With one exception, there is no law in Wisconsin which legalizes a nontherapeutic sterilization. That exception is an inmate of criminal and mental institutions who may be sterilized under provisions of sec. 46.12, of the Statutes, where certain requirements are strictly observed. We find nothing in the Wisconsin Statutes, court decisions or Opinions of the Attorney General which makes lawful a vasectomy on a healthy husband which was performed only because of the health of his wife. Sterilization is tolerated by the law only if it benefits the health of the patient on whom the surgery is performed.

As only one example of possible future complications, a later marriage by the male could be jeopardized by reason of the vasectomy.

To summarize, it is our opinion that the public policy of this state, as declared either by the Legislature or the courts, permits sterilization for clearly therapeutic purposes but does not permit the nontherapeutic sterilization of any person except as permitted by section 46.12 of the Wisconsin Statutes in the case of certain criminal and mental cases. That section clearly does not sanction the sterilization of the husband to safeguard his wife's health.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 149.10(1) of the Wisconsin Statutes defines "professional nursing", and Section 149.10(2) defines "practical nursing". These definitions are as follows:

> "149.10 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician*, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing within the terms of this chapter means the performance of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge, or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* simple acts in the care of convalescent and other specified persons, but also "*any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what is described in the first part of subsection (2). A

trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin, 53701.

Consents for Treatment of a Minor

A minor is defined by the Wisconsin Statutes as a person who is under 21. Consents to treatment are necessary for minors as well as for those over 21. Consents may be oral as well as written, but unless a physician can produce disinterested witnesses with good memories, he will do better to have the consent in writing.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless such relative has been appointed as such minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an *emergency*, a consent is *not* necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law *implies* the consent of the patient, or in the case of a minor, of his parent or guardian. BECAUSE THE LAW DOES NOT IMPLY CONSENT BEYOND THE TREATMENT ACTUALLY NECESSARY TO MEET AN EMERGENCY, THE PHYSICIAN MAY SAFELY TREAT ONLY THE EMERGENCY CONDITION ITSELF, AND NOTHING ELSE, WITHOUT ACTUAL CONSENT OF A PARENT OR GUARDIAN.

Second, an *emancipated* minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

Note: On the subject of consents generally, see 1958 *Blue Book* issue of this JOURNAL, Vol. 57, issue 1, pages 4–58.

Legal Limitations on Treating the Sick in Wisconsin

An Interpretation of The Medical Practice Act

MORE THAN one hundred years ago the medical profession organized nationally and, in many states, for the principal purpose of elevating the standards of medical education and encouraging adequate licensing laws throughout the United States. In Wisconsin the legislature established the State Medical Society in 1841.

Only during the past 50 years have states adopted effective medical practice acts which restrict the unqualified and impose minimal requirements upon those seeking medical licensure. During the same period the voluntary efforts have revolutionized medical school requirements and standards.

The development of Wisconsin's Medical Practice Act is typical of legislative response to public demands for protection against the incompetent, the quack, the cultist and the charlatan. The legislative power to regulate the professions with a "public interest" has been acknowledged for many years. It has only been exercised when either the public has become outraged or when the professions themselves have attempted to raise their own standards.

The first legislative step in this state to help assure qualified practitioners appeared in Chapter 27, Revised Statutes, 1849. It imposed the duty of examining medical students upon the censors of the county and state medical societies. Upon successfully completing his examination, the student paid the president of the society $10 for a diploma and membership in the society. This diploma and membership was little more than a badge of honor.

This type of statutory delegation of power to the medical societies continued until 1897 when the Wisconsin legislature first enacted a real Medical Practice Act.[1] This act established the first state board of medical examiners of seven members appointed by the Governor. Three of the appointees were "regular physicians," two were "homeopathic physicians," and two were "eclectic physicians."

The homeopathics and eclectics in Wisconsin each had their own state societies. As standards of medical education improved, both gradually abandoned their exclusive theories of treatment and were assimilated into what is now known as the "practice of medicine." Their state societies eventually died for lack of members. In 1953 the last vestiges of homeopathy and eclecticism were removed from the statutes by elimination of the homeopathic representative on the board of medical examiners.

It is interesting to compare the license application requirements, then and now. An applicant had the alternative of submitting to an examination "in the various branches of medicine and surgery" or presenting to the board a diploma from a medical college which required "at least three courses, of no less than six months each, before graduation."[2] Thus practical training with a "respectable" physician remained an avenue to licensed medical practice, but the pattern of effective control of medical qualification was established.

The 1897 Act made no provision for the licensing of those already in medical practice on the date it became effective. The next legislature required "every reputable physician of good moral character" who wished to continue in practice to register with the board and to present a diploma or other credentials. A registration certificate was then issued which was required to be filed with the county in which the physician practiced. Criminal penalties were provided for noncompliance.[3]

This requirement of medical license or certificate was a blow to osteopathy whose practitioners had, by this time, established themselves in Wisconsin. The legislature, in its 1901 session, added an osteopath to the board of medical examiners, provided for examination and licensure in osteopathy, but permitted all those already in practice to continue under a typical "grandfather's" clause.[4]

The same legislature increased the requirements for medical education to four courses of not less than seven months, with at least an equivalent of two years of high school, and, more significantly, required both an examination and a diploma as a condition to medical license. Those presenting a diploma from a medical school in Wisconsin, however, were exempt from the examination requirement.[5] These amendments marked an end to practical experience with a preceptor as an alternative to medical school education for licensure.

As with eclecticism and homeopathy, the osteopaths gradually began to abandon their cult theory and practice. There was evidence that some of their

schools were interested in and were improving their standards and facilities.

In 1949 the Medical Practice Act was amended to eliminate separate licensing of osteopaths. Thereafter licenses to practice medicine and surgery were issued, under the usual conditions, to applicants presenting diplomas from a "medical or osteopathic college with standards of education and training substantially equivalent to the University of Wisconsin medical school, approved and recognized by the board."[6]

Osteopaths already licensed and in practice were permitted to enroll in a prescribed course in materia medica and pharmacology and, upon successfully completing an examination by the board in those subjects, received an unlimited license to practice medicine and surgery upon surrender of their old license.[7]

By 1915 the chiropractors had come into Wisconsin. That session of the legislature authorized chiropractors to practice so long as they did not hold themselves out as licensed or registered.[8]

Lurking in the background at this time were the naturopaths, the naprapaths, the faith healers, quacks, charlatans and others ready and eager to follow the lead of the chiropractors to unqualified legislative recognition—or exemption from educational and training requirements.

Thus, one of the significant modern legislative actions in the public health interest was the enactment of the Basic Science Law by the 1925 legislature. It will be considered in some detail later. Generally, however, and with some limited exemptions, it imposed minimal qualifications upon all who would "treat the sick" in Wisconsin. It is sufficiently inclusive in its scope that it is the law most frequently used in prosecutions against the unlicensed.

In summary, Wisconsin joined with other states more than a hundred years ago in appreciating the absolute need for the imposition of adequate standards to assure qualified health care to its people. These legislative standards and the mechanisms through which they could be enforced developed and improved through the years.

Wisconsin, along with other states, experienced the growth of cultism and potent efforts to undermine qualifying legislation which had been so painstakingly achieved. The development of these cults and the legislative treatment of them has been briefly traced. Let us now consider specifically the Basic Science Law and the Medical Practice Act.

THE BASIC SCIENCE LAW

General Provisions

In 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin legislature enacted the Basic Science Law, the first statute of its kind. More than 20 states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does *not* authorize one who has successfully passed the examination to engage in any form or manner of caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and physical diagnosis,[9] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless be has a certificate of registration in the basic sciences.[10] *But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.*[11] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.[12]

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the army, navy, and federal health service,[13] registered nurses,[14] dental hygienists,[15] optometrists,[16] physical therapists,[17] and persons practicing Christian Science.[18] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[19] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[20]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin were granted the opportunity of being registered upon application to the board.[21] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

All Inclusive Definition of "Treating the Sick"

Section 147.01 (1), Wisconsin Statutes, 1961, thus defines what constitutes treating the sick in Wisconsin:

> "(a) To 'treat the sick' is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof."
>
> "(b) 'Disease' includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

Such departures from complete health, as astigmatism, headaches and partial paralysis, constitute

"disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[22] The use of roentgenography for diagnosis and treatment is treatment of the sick.[23] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[24] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[25]

Board of Examiners in the Basic Sciences

The state board of examiners in the basic sciences consists of three educators appointed by the Governor to serve for a term of six years each.[26] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[27]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, and all other disbursements by the board, may not exceed in amount the fees received.[28]

Application for Certificate

Application for a certificate of registration must be made to the board of examiners in the basic sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[29] The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.[30]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[31]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[32] The applicant is examined in anatomy, physiology, pathology and physical diagnosis,[33] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be re-examined in that subject at any examination within one year without further fees, but if he fails in two or more, he must re-apply and be re-examined in all subjects.[34]

If the state boards of medical or dental examiners accept in whole or in part certifications from their national boards of examiners, the basic science board may accept such national certificates in lieu of their own examinations.[35]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[36]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[37]

Court Review

The action of the board in granting or denying a certificate is subject to review by appeal in the manner provided in Chapter 227, Wisconsin Statutes. The applicant affected, or any state examining board for any branch of treating the sick, may take such appeal.[38]

The court may then affirm, reverse, or modify the decision of the board, in the manner provided by administrative appeals.[39]

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in section 147.20, Wisconsin Statutes.[40] For discussion of that section and procedure under it see "Revocation or Suspension of License," page 28, of this article.

Enforcement of the Basic Science Law

The definition of the phrase "treat the sick" and of "disease" are sufficiently broad to encompass even the "hair restorer" and the "headache reliever" as has been seen. All who "treat the sick" are *required* to have a certificate in the basic sciences with the noted exceptions.

Of equal importance is the fact that the law is readily enforceable. In addition to a criminal penalty of a fine or imprisonment,[41] the board of medical examiners or the district attorney of the proper county may bring action in the name and on behalf of the state to enjoin a violation.[42] It has been the latter procedure which has proved most effective.

LICENSING REQUIREMENTS AND PROCEDURES AFTER CERTIFICATION IN THE BASIC SCIENCES

As has been noted, a basic science certificate does not entitle its holder to treat the sick. This is further clarified in section 147.14 (1), Wisconsin Statutes, 1961:

"147.14. Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating the sick as the term 'treat the sick' is defined in s. 147.01 (1) (a), without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute."

Exceptions to this provision include those engaged in healing the sick through Christian Science,[43] while still another provision exempts those engaged as commissioned officers of the army, navy, or federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[44]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin may not be pursued as a vocation. This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[45]

Each specific licensed field in Wisconsin is under the jurisdiction of one of the several licensing boards. The state board of medical examiners licenses or registers successful applicants for the practice of medicine and surgery, physical therapy, and podiatry.

Of those rendering health care in any form only persons licensed to practice medicine and surgery are permitted by Wisconsin law to practice without limitation. All others are limited either as to the scope of practice or as to modalities or treatment methods which may be employed. It is not the purpose of this article to set forth those limitations. Licensure requirements, application procedures, powers and organizations of the respective licensing boards, license revocation and disciplinary procedures will be treated, however, as will statutory provisions of particular interest and importance to the particular field of practice involved.

MEDICINE AND SURGERY

Examining Board

The examining body for applicants for license to practice medicine and surgery is the state board of medical examiners, composed of seven licensed resident doctors of medicine and one licensed resident doctor of osteopathy, all appointed by the Governor for four-year terms.[46] No instructor, stockholder, member of, or person financially interested in any school having a medical or osteopathic department, is eligible.[47]

The board has its permanent office in Madison and is required to meet at least four times a year, one meeting of which must be on the second Tuesday of January at Madison for the purpose of electing its officers.[48] It keeps a register of the applications it receives and the licenses and certificates of registration issued.[49]

All persons licensed or registered by the board are required to register with it annually and pay the required fee, which the board sets annually up to a maximum of $10. These include those licensed or registered to practice medicine and surgery,[50] osteopathy,[51] podiatry,[52] and physical therapy.[53]

Such annual re-registration requirement must be complied with in January of each year and the board is required to publish a printed list of all registrants before March 11 and mail a copy to each registrant and to designate law enforcement officials including the sheriff and district attorney of each county.[54]

All applications for licensure from the board must be presented at the time and place designated by it.[55] In this connection, the board, in the exercise of its rule-making authority, has adopted a wide range of regulations detailing its specific requirements as to the procedure in making application for licensure.[56] These are subject to frequent change; therefore, it is suggested that specific inquiry be directed to the offices of the State Board of Medical Examiners, 1414 South Park Street, Madison, Wisconsin 53715.

Educational Requirements

The minimal educational requirements of an applicant for license to practice medicine and surgery are summarized in Table 1, Columns 2, 3 and 4, page 25.

The medical or osteopathic college from which the applicant has graduated must be "substantially equivalent" in its standards of education and training to the University of Wisconsin Medical School and approved and recognized by the board on this basis.[57]

Inquiry as to whether a particular college has been approved should be directed to the office of the board. As to colleges not already approved and recognized, the board or a designated agent is required to conduct an investigation and a public hearing with notice to all interested parties.[58]

Examination and Licensure

The state board of medical examiners examines all applicants in subjects usually taught in a reputable medical school.[59] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[60]

TABLE 1—*Requirements of an Applicant for a License in Medicine and Surgery, Dentistry, Nursing, Podiatry, Optometry and Chiropractic*

1. Applicant for License in	2. Preliminary	3. Undergraduate	4. Personal, Professional or Occupational	5. Additional Legal Requirements	6. Application Fee
Medicine and Surgery (Secs. 147.15; 147.17 (1))	Equivalent to graduation from an accredited high school of this state.	Equivalent to the premedical course at the University of Wisconsin, including physics, chemistry and biology.	Good moral and professional character; diploma from reputable professional college approved and recognized by board of medical examiners with standards of education and training substantially equivalent to the 4 year course of the University of Wisconsin medical school.	Certification of registration in basic sciences. If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital; a verified statement of familiarity with health requirements on communicable diseases.	$45, with an additional $5 if license issued. Special charges for foreign language applicants.
Dentistry (Sec. 152.03)	Equivalent to graduation from a high school or academy in Wisconsin offering a 4 year curriculum beyond the 8th grade.	2 years college preparation leading to a baccalaureate degree including courses in English, physics, biology and chemistry.	Satisfactory completion of dental school and college approved by the Wisconsin state board of dental examiners, with a curriculum of at least 4 years of 32 weeks each.	Certificate of registration in basic sciences.	$25
Nursing (a) Registered Nurse (Secs. 149.04; 147.02)	Equivalent to high school education.		Good moral character, citizen, or intends to be citizen. Diploma of graduation from a school of nursing accredited by the board of nursing.	None; specifically exempt from Basic Science Law.	$25
(b) Trained Practical Nurse (Sec. 149.09 (2))	2 years of high school or equivalent.		Good moral character, citizen, or intends to be citizen, 18 years of age. Completed work prescribed by an accredited school for trained practical nurses approved by the board of nursing.		$15
Podiatry (Secs. 154.02; 147.02; 147.04)	Equivalent to graduation from an accredited high school.	1 year in an accredited college of liberal arts or science.	Good moral and professional character and over 21. Graduation from an accredited school of podiatry including courses in anatomy and physiology of the feet, diagnosis of foot ailments and deformities, chiropodial orthopedics, minor surgery and bandaging pertaining to ailments of the feet, mechanical treatment of congenital or acquired deformities of the feet and materia medica. Podiatric school must have professional curriculum of 4 years, of at least 32 weeks each, at least 30 class hours per week, and adequate clinical or hospital facilities. Allowed to use title "Doctor of Surgical Chiropody" or its equivalent.	Certificate of registration in basic sciences.	$25
Optometry (Secs. 153.04, 153.05, and 147.01 (2))	None	None	Good moral character, 21 years old. Graduation from an accredited college of optometry approved and recognized by optometry board, and 5 years approved training in optometry, of which 3 years must have been in an accredited school or college of optometry.	None; specifically exempt from Basic Science Law.	$35 for resident $50 for non-resident $10 for subsequent examination in event of failure.
Chiropractic (Sec. 147.23 (3))	None	2 years of study for a Bachelor of Arts or Science degree in a college accredited by the North Central Association of Colleges and Secondary Schools.	Satisfactory evidence of good moral character. Graduation from a reputable school of chiropractic, approved and recognized by the board of examiners in chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class periods.	Certificate of registration in basic sciences.	$25

Licensure by Reciprocity

The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the army or navy, or of the federal public health service, upon filing of a sworn and authenticated copy of his discharge.[61]

Special Provisions

Three pieces of postwar legislation have been enacted at the request of the State Medical Society in an effort to assure the maximum availability of medical resources in our state.

1. Applicants from Unapproved Foreign Medical Schools[62]

As has been noted, an applicant for a license to practice medicine and surgery must present to the board of medical examiners a diploma from a medical or osteopathic college *approved and recognized by the board.* A number of foreign medical schools are not. Some which are have that approval only during specified graduating years.

A carefully restricted opportunity for applicants who cannot present a diploma from such an approved school was provided by the 1957 session of the Wisconsin legislature.

If the board is persuaded that a graduate of an unapproved and unrecognized foreign medical school has preprofessional and professional training substantially equivalent to that offered by the University of Wisconsin premedical and medical schools, it may admit the applicant to examination and issue a license to practice medicine and surgery.

The board may ask the dean of a medical school, which has been approved by the board, to examine or have examined the applicant to determine whether the premedical and medical training is substantially equivalent to that offered in the dean's school. In lieu of the inquiry of a dean, the board may accept, either in whole or in part, the marks received by the applicant in examinations conducted by the educational council for foreign medical graduates.

Only 25 licenses a year may be issued to applicants. The fee is based upon the time of the examiner and board but is not less than $100 or more than $300.

2. Temporary Licenses to Practice Medicine and Surgery[63]

Several months may elapse between the time an obviously qualified physician applies for a Wisconsin license and the board conducts its next examination.

Provision has been made by statute under which any two officers of the board of medical examiners may cause to be issued a temporary license to practice medicine and surgery to such an applicant.

Two such officers must first find, however, that an emergency need for medical personnel in a particular area exists and the temporary license must limit its holder to practice in that area.

This statute contemplates that the temporary licensee will submit to the next board examination for permanent license. To that end a temporary license expires within 30 days after the next examination for permanent license is conducted by the board or on the date the board grants or denies the applicant a license—whichever date first occurs. If the temporary licensee does not take the examination, the license expires on the day the board begins its examination of applicants.

A temporary license may be issued only once to the same person; and, during the period it is in force, the basic science law certificate requirement is suspended, assuming the temporary licensee has applied for a basic science certificate and the application has been accepted by the basic science board.

The fee for a temporary license is $25.

3. Temporary Educational Certificates in Medicine and Surgery[64]

For the stated single purpose of providing opportunities in Wisconsin for the postgraduate education of certain persons in medicine and surgery who do not possess a license and, presumably, are not eligible for one, the board of medical examiners may issue educational certificates under prescribed conditions.

An applicant for such a certificate must have training in medicine and surgery satisfactory to the board. It may be issued for a period not to exceed one year. It may be renewed annually, at the discretion of the board, for not more than four additional years. No more than 50 temporary educational certificates can be issued annually and no more than 150 may be outstanding at any one time.

The certificate permits its holders to take postgraduate educational training only in a teaching hospital which maintains standards prescribed by the board and are commensurate with those of nationally recognized accrediting organizations. He may render services to patients only under the direction of a person licensed to practice medicine and surgery in Wisconsin.

Under such medical direction, the educational certificate holder may prescribe drugs other than narcotics and sign certificates, reports and other papers required, or for the use of public authorities which are required of or permitted to one licensed to practice medicine and surgery.

Additional restrictions are these: The certificate holder must confine his training and practice within the hospital in which he is taking his postgraduate education, and neither he nor the hospital may receive fees or other income for his services from any patients treated by him.

The Status of Externs, Interns and Residents

1. Externs

The term "extern" or "preceptee" refers to medical students in their last two or clinical years, who have not as yet completed their college course in medicine. A preceptee performs certain assisting and observing functions, either during a vacation period, or during his fourth year of medical study, under the supervision of a licensed physician. Preceptees participate in this portion of their training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

A preceptee is generally an assistant to a physician. The duties delegated to a preceptee by a physician are usually very much limited and relate only to observation. Thus, a situation would seldom arise in which an act of a preceptee might cause injury. A physician has the duty to see to it that the preceptee is delegated no duty which would call for discretion or judgment on his part. However, a negligent act on the part of a preceptee in the treatment of a patient is the responsibility of the physician under whom he is working. A preceptee is unlicensed; hence he cannot practice medicine.

2. Interns

An "intern" is generally understood to mean one who is engaged in a twelve month period of advanced study immediately subsequent to the completion of his college course and prior to the granting of his medical license. Internship is a prerequisite for the granting of a license to practice medicine and surgery in Wisconsin. After one year of internship, unless his medical school requires a longer period as a condition of graduation, the intern must be licensed and have the legal status of a practicing physician.

An intern does not have the full legal status of a licensed practitioner. He does have certain functions of a medical nature which he is permitted to perform. The Wisconsin Supreme Court has admitted that interns are not subject to the Medical Practice Act because the Wisconsin statutes require an internship as a part of one's medical education prior to licensure. The court summarized the legal status of an intern in Wisconsin as follows:

> "This is a legal sanction of the performance of such duties on the part of interns as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine, or a representation

that the intern is authorized to practice medicine."[65]

Interns are not within the provisions of the so-called "medical privilege statute."

When it comes to responsibility for negligence of interns while performing their customary duties, it is clear that they have a personal responsibility. The responsibility for their acts, however, may extend to the physicians under whom they are working, or to the hospital employing them. The law generally holds the intern to be an employee or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents, within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the Workmen's Compensation Act, which extends employee protection to interns injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of interns in the performance of duties which are customarily performed by them. However, where the intern is acting under the direct supervision of a physician during the course of an operation, the hospital is absolved from responsibility and his acts become those of the physician who has charge of the work.

3. Residents

A "resident" is usually understood to mean a physician engaged in postgraduate medical education beyond the period of internship, and under the supervision of a hospital medical staff or a medical faculty. A resident is required by Wisconsin law to hold a regular, permanent license to practice medicine. He is as fully responsible for his acts or omissions as any other licensed practitioner.

Revocation or Suspension of License

Procedures have been established by statute for the revocation or suspension of a license or certificate issued by the Wisconsin state board of medical examiners:

1. By Civil Action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke or suspend his license upon a verified complaint received by him charging the holder of the license with having been guilty of immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[66] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

> "(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of 'lost manhood,' the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses reestablished, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee; or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude; (g) engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public."

The license of a physician who attempts to perform an abortion may be revoked or suspended, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[67] Nor is the time important within which to bring such action, after the offense has been committed.[68] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty as an accessory before the fact, and his license is subject to revocation or suspension under this section.[69]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under that section.[70]

2. By Action of the Board

The statute also provides that when any person licensed by the state board of medical examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke or suspend the license or certificate. The board is likewise under a duty to revoke or suspend any such license or certificate upon proof of a federal conviction of a crime committed in the course of the holder's professional conduct.[71]

The license of a physician who has been convicted of a crime cannot be revoked or suspended by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked or suspended by a circuit court action described in part (a) of this section.[72]

Revocation or suspension of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[73] There is no time limitation within which the board must act. In the event, however, that the board suspends rather than revokes the license or certificate, the suspension must be for a definite period not exceeding two years, and the board has the power, upon a proper showing, to restore it at any time within the period.[74]

The board has no authority to restore a revoked license.[75] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the state board of medical examiners and upon findings by the court that the applicant is of good moral and professional character and that justice demands the restoration.[76]

Still another subsection permits the holder of a license or certificate of registration to surrender it voluntarily, after which it may be reissued only as justice demands.[77] A subsection enacted in 1961 permits the board, without formal proceedings, to suspend a license or certificate temporarily and to place its holder on probation for up to three months where it is known or the board has good cause to believe that the holder has been guilty of immoral or unprofessional conduct. The board is not authorized to suspend a license or certificate or to place a holder on probation for more than two consecutive three-month periods. All board actions under this subsection are reviewable by a court under Chapter 227 of the statutes. The board also has authority to warn and reprimand the holder of a license or certificate and to request the state medical grievance committee to act under section 147.195, discussed in subsection 3. immediately following.[77a]

3. State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[78] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health.

The statute follows:

> "147.195. State medical grievance committee. The state health officer, the secretary of the state board of medical examiners, and the attorney general or deputy attorney general, or their representatives, are hereby constituted ex officio a state medical grievance committee, to investigate, hear and act upon practices by persons licensed to practice medicine and surgery under 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon. All divisions, officials and employees of state and local government are authorized to cooperate with the committee in conducting investigations and by making available to it pertinent data in their possession."

OSTEOPATHY

Since 1949 osteopaths have not been licensed as such in Wisconsin. In recent years the Wisconsin legislature became satisfied that osteopathy, as with homeopathy, had abandoned its cult background and therapy. It enacted legislation providing that if an applicant presented to the state board of medical examiners a diploma from an osteopathic college *with standards of education and training substantially equivalent to the University of Wisconsin medical school* and which school was approved by the board, a license to practice medicine and surgery would be issued. This is conditioned, of course, upon the applicant's meeting all other prequalification requirements for medical licensure including examination.[79] These are set forth in Table 1 appearing at page 25.

Provision was made in the same legislative enactment through which those osteopaths, previously licensed by the board to practice osteopathy and surgery, could qualify for the unlimited license to practice medicine and surgery. An osteopath may now seek only the unlimited license and is required to take a prescribed course, approved by the board of medical examiners, in materia medica and pharmacology and to pass the same examination in the subjects as given to a medical school graduate at any regular meeting of the board.[80]

Limitations on Practice

The graduate of an osteopathic school who holds a license to practice medicine and surgery is prohibited from using the title "doctor of medicine" or the letters "M.D."[81] Other than that his license to practice medicine and surgery is identical in its unlimited privileges with that of the doctor of medicine.

There is a sufficient number of osteopaths, licensed as such, and still in practice, who did not seek or gain the unlimited license to warrant a brief statement of the limitations imposed upon their practice by Wisconsin law.

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[82]

Under the earlier statutory provisions that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[83] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[84]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so. . ."[85]

PODIATRY

The practice of podiatry, previously called chiropody, has been legislatively recognized and controlled in Wisconsin since 1917. Its practitioners are registered by the state board of medical examiners after the applicant meets the prequalification requirements outlined in Table 1 appearing at page 25, and, successfully passes an examination conducted by three licensed podiatrists appointed by the board.[86]

The 1961 legislature substantially broadened the practice of podiatry. The scope of their practice is now defined by statute as follows:

> "(1) The practice of podiatry is the diagnosis or mechanical, medical or surgical treatment, or treatment by the use of drugs, of the feet, but does not include major surgery or the use of a general anesthetic. Diagnosis or treatment shall include no portion of the body above the feet except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in the conditions of the feet."[87]

Since podiatrists attempted to obtain authorization for the use of narcotics from the legislature and were refused, it is clear that they may not use narcotics.[88]

Although unnecessary by virtue of their unlimited license, physicians are specifically exempt from a provision of the podiatry chapter that no one may practice in this area unless registered by the state board of medical examiners to do so.[89]

CHIROPRACTIC

The practice of chiropractic has been licensed in Wisconsin since 1925. It has its own licensing board consisting of three chiropractors, appointed by the Governor with the advice and consent of the Senate.[90]

An applicant for chiropractic license must present to the board a certificate of registration in the basic sciences and otherwise meet the prequalification requirements outlined in Table 1 appearing at page 25.[91]

The theory of chiropractic is set forth in rules which have been adopted by the state board of examiners in chiropractic. It is based on the premise that disease or abnormal function is caused by interference with the normal nerve transmission and expression, due primarily to pressure, strain, irritation or tension upon the spinal nerves as they emit from the spinal column, as a result of bony segments, especially of the spine, deviating from their normal juxtaposition.[92]

Limitations on Practice

The practice of chiropractic is defined by board rule. It provides as follows:

> "The practice of chiropractic consists of the analysis of any interference with normal nerve transmission and expression and the correction thereof by a specific adjustment with the hands of the abnormal deviations of the bony articulations especially of the spine, for the removal of the cause of disease, without the use of drugs or surgery. The term, analysis, is construed to include the use of x-ray and other analytical instruments generally used in the practice of chiropractic."[93]

OPTOMETRY

Optometrists are licensed in Wisconsin by a board of five members, appointed by the Governor, and designated as the Wisconsin board of examiners in optometry.[94] An applicant for a license in optometry must meet the requirements outlined in Table 1 appearing at page 25, and successfully pass an examination conducted by the board. The Wisconsin Supreme Court has ruled that: ". . . optometry is not a part of the practice of medicine."[95] Optometrists are specifically exempt from the Basic Science Law thus making the court decision and the statute consistent.[95a]

Limitations on Practice

The optometry statute provides in part:

> "The practice of optometry is defined as follows: The employment of any means other than drugs to determine the visual efficiency of human eyes or the measurement of the powers or defects of vision; the furnishing, using or employment of any means or device designed or calculated to aid in the selection or fitting of spectacles or eyeglasses; and the adaptation of lenses, prisms and mechanical therapy to aid the vision of any person."[96]

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaptation of lenses, prisms and mechanical therapy for the aid thereof.[97] It is a mechanical trade, not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involv-

ing a relation of special confidence between practitioner and patient."[98]

No one is permitted to practice optometry, as it is defined above, unless he has been licensed by the board of examiners in optometry.[99] Physicians are excepted, however.[100] So too are dispensing opticians to the limited extent that they may take necessary facial measurements and process, fit and adjust mountings, frames, lenses and kindred products in the filling of prescriptions of duly licensed physicians or optometrists for ophthalmic lenses. They may also duplicate or replace lenses without a prescription in those instances where "optometric service" is not required.[101]

FEE SPLITTING

The 1959 session of the legislature revised the fee splitting statute.[102] As a result of that revision the State Medical Society prepared a Guide to the new law. The Guide is available to physicians upon request to the State Medical Society of Wisconsin. The 1962 issue of the Blue Book, *Wisconsin Medical Journal*, Vol. 61–No. 1, contains further material in an article beginning on page 3 of that issue.

The statute, section 147.225, is of sufficient length so that it is not practical to reprint it in full in this article.

The essence of the statute is that each physician must render a separate billing to each patient,[103] with the exception of physicians employed by one or more other physicians, partnerships[104] and certain consultants under contract with hospitals to provide services to attending physicians.[105]

There are criminal penalties attaching to fee splitting, and therefore, if any physician has questions concerning the statute, he should consult his attorney as well as the information provided by the State Medical Society.

ENFORCEMENT OF THE MEDICAL PRACTICE ACT

The obligation of enforcing the Medical Practice Act is vested in the state board of medical examiners.[106] The board or the district attorney of the proper county may investigate any alleged or known violations. Enforcement funds are secured from the annual re-registration fee paid to the board by its licensees and registrants.

Both criminal and civil remedies are available to the board. Violations of the Medical Practice Act call for a fine of not less than $100 nor more than $500, or imprisonment for not less than 60 days nor more than one year, or both.[107]

The civil remedies include that of injunction. The board or the district attorney of the proper county may bring action in the name and in behalf of the State of Wisconsin against a violator to enjoin him from further violations.[108]

CITATIONS

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1961 Wisconsin Statutes as amended by the Laws of 1963 through October 15, 1963. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official *Opinions* of the Attorney General of Wisconsin.

1. Chapter 264, Laws of 1897
2. Ibid
3. Chapter 87, Laws of 1899
4. Chapter 306, Laws of 1901
5. Ibid
6. Chapter 431, Laws of 1949
7. Ibid
8. Chapter 438, Laws of 1915
9. Sec. 147.01 (1) (c)
10. Sec. 147.02
11. Sec. 147.14 (1)
12. Sec. 147.04
13. Secs. 147.02; 147.19 (1)
14. Sec. 147.02
15. Sec. 147.01 (2)
16. Ibid
17. Sec. 147.02
18. Secs. 147.02; 147.19 (2)
19. Secs. 147.02; 147.19 (1)
20. Secs. 147.02; 147.19 (1)
21. Sec. 147.09
22. Nickell v. State (1931) 205 Wis. 614
23. 16 Atty. Gen. 560
24. 20 Atty. Gen. 107
25. 21 Atty. Gen. 1135
26. Sec. 147.03
27. Ibid
28. Sec. 147.12
29. Sec. 147.05
30. Sec. 147.06
31. Sec. 147.05; 22 Atty. Gen. 297
32. Sec. 147.06
33. Ibid; Sec. 147.01 (1), (c)
34. Sec. 147.07
35. Sec. 147.06. The section also requires that the basic science boards of at least six other states must accept the certificate of the national board of medical examiners before the Wisconsin basic science board has the option of doing so.
36. 26 Atty. Gen. 110
37. Sec. 147.08
38. Sec. 147.11
39. Sec. 227.20 (1)
40. Sec. 147.10
41. Sec. 147.21
42. Sec. 147.205
43. Sec. 147.19 (2)
44. Sec. 147.19 (1)
45. Sec. 147.14 (1)
46. Sec. 147.13 (1)
47. Ibid
48. Sec. 147.13 (2)
49. Sec. 147.13 (5)
50. Sec. 147.175
51. Ibid
52. Sec. 154.04
53. Sec. 147.185 (4)
54. Sec. 147.175 (1), (3)
55. Sec. 147.15
56. Ibid; Wisconsin Administrative Code Med. 1.01–10.08
57. Sec. 147.15
58. Ibid
59. Sec. 147.16
60. Sec. 147.17
61. Ibid
62. Sec. 147.15 (1m)
63. Sec. 147.15 (2)
64. Sec. 147.151
65. Nickley v. Eisenberg (1931) 206 Wis. 265, 267–270
66. Sec. 147.20 (2)
67. 12 Atty. Gen. 144; State v. Lewis (1916) 164 Wis. 363
68. State v. Schaeffer (1906) 129 Wis. 459, 467
69. 24 Atty. Gen. 108
70. 18 Atty. Gen. 289; 21 Atty. Gen. 176
71. Sec. 147.20 (3)

72. 18 Atty. Gen. 289
73. 26 Atty. Gen. 378
74. Sec. 147.20 (5)
75. 2 Atty. Gen. 571
76. Sec. 147.20 (4); 22 Atty. Gen. 942
77. Sec. 147.20 (6)
77a. Sec. 147.20 (7)
78. Sec. 147.195
79. Sec. 147.15 (1)
80. Sec. 147.17 (3)
81. Sec. 147.17 (6)
82. Herzog, Medical Jurisprudence, Sec. 121; Arnold v. Schmidt (1913) 155 Wis. 55, 61
83. 10 Atty. Gen. 837; 29 Atty. Gen. 148
84. 14 Atty. Gen 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137, 163
85. 29 Atty. Gen. 148, 153
86. Secs. 154.04; 154.03
87. Sec. 154.01 (1)
88. Bill 345, A., 1961 Legislature
89. Sec. 154.01 (2)
90. Sec. 147.23 (2)
91. Sec. 147.23 (3)
92. Wisconsin Administrative Code, Chir. 1.14
93. Ibid
94. Sec. 153.03 (1)
95. *State ex rel Harris vs. Kindy Optical Company* (1940) 235 Wis. 498, 501
95a. Sec. 147.01 (2)
96. Sec. 153.01 (1)
97. Sec. 153.01
98. *State ex rel Harris vs. Kindy Optical Company* (1940) 235 Wis. 498, 501
99. Sec. 153.02 (1)
100. Sec. 153.02 (2)
101. Sec. 153.01 (2)
102. Chapter 484, Laws of 1959
103. Sec. 147.225 (1)
104. Sec. 147.225 (2)
105. Sec. 147.225 (3)
106. Secs. 147.13 (6); 147.205 (1)
107. Sec. 147.21
108. Sec. 147.205 (1)

THE PHYSICIAN AND LEGAL MEDICINE

The *Journal* of the AMA for September 7, 1963, contained an article entitled, "YOUR Professional Liability, 131 Questions and Answers." The questions include many which physicians are likely to encounter in their daily practice.

The answers follow the general rule of law in some instances, or the only rule in the case of other questions as to which there is very little court authority. This procedure was necessary when writing for physicians of the entire country but gives no assurance that the Wisconsin court has followed or will follow such rule were the same question before it. There may thus be some differences between answers given in the AMA article and those which an attorney would give to a Wisconsin physician.

The last paragraph of the introduction of the AMA article is sufficiently important to merit repetition. It states:

> "The following questions and answers do not eliminate the need for legal advice. Rather they help the physician to determine when it is necessary to call upon his personal attorney for such advice."

See JAMA, September 7, 1963, Vol. 185, No. 10, pp. 789–806.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Motor Vehicle Department and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: Section 343.09, Wisconsin Statutes, 1961.

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

What Every Doctor Should Know about Workmen's Compensation

INFORMATION about the Workmen's Compensation Act is news of direct interest to virtually every physician in Wisconsin, irrespective of his specialty or location.

The law applies to more than 70,000 employers who have three or more employees. Farmers are excluded unless they employ 6 or more employees on any 20 days in a calendar year. If any one of the more than one million employees covered by the act receives an injury or disease during the course of his employment, the law makes the employer liable to provide certain indemnities and to provide or pay for such medical attention as may be needed to bring about rehabilitation.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employees under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Industrial Commission of Wisconsin. Other standards or schedules are fine for your own information, but only the Commission's standards are authoritative in Wisconsin.

★ Submit your reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and professional fees to the physician. Quite often the unexpected misfortune places the employee in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society, Box 1109, Madison, Wis. 53701, or Mr. R. E. Gintz, Director of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Madison, Wis. 53702.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 27 years of experience with the Workmen's Compensation Act.

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Industrial Commission. To establish this claim a medical report verifying and specifying the workman's injuries or diseases and the degree of disability is necessary. The Industrial Commission and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he is required to supply the injured employee with "such medical-surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances . . . as may be reasonably required to cure and relieve from the effects of the injury."

Q. How does the Industrial Commission determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant. They are an employer-employee relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employees under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employees and to permit the employees to make a choice of their physicians from among them.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object

was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employees may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. About every three years the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed on the next panel. However, a physician may at any time request listing or removal. The panels will not be changed until the next printing, but inquiries directed to the office of the Society will be answered on the basis of the current participation of each member.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The State Medical Society panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Panels are distributed by another group of unlimited licensees, but these are not part of the State Medical Society program.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Usually the employer or his Workmen's Compensation insurance company pays the physician. This is true where it is conceded that the injury was sustained on the job and that the treatment rendered was necessary because of such injury.

Where there is a dispute and it is found by the Industrial Commission that the case is not covered by the Workmen's Compensation Act, the employer is still liable for treatment authorized by him. On the other hand, the employee–patient is liable for unauthorized treatment. The Industrial Commission determines what treatment is covered under the Workmen's Compensation Act.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employee has complete free choice. Then the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employee does not give notice of his need for treatment, or he refuses to accept the panel physician. Then the employer has no liability and the Commission no jurisdiction to determine necessity or reasonableness.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule communications from a patient to an attending physician are privileged. The Workmen's Compensation Act creates an exception to the law of privilege. The law provides that any physician attending a Workmen's Compensation claimant furnish to the employee, the employer, the Workmen's Compensation insurance carrier or the Commission information and reports relative to a compensation claim. The Commission explains that it is a practical necessity for physicians to furnish information. Physicians will not be required to disclose confidential communications transmitted to them unless such information is necessary to a

proper disposition of the claim. The physician's testimony before the Commission should be absolutely fair, factual and unbiased.

Q. Does this mean that the physician need not divulge any information to the employer about an employee who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employee when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Industrial Commission has the right to request a complete report on an injured employee. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other information than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employee and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Therefore, doctors must be interested in whether the injury or disease was suffered in the course of employment and arose out of the employment.

When the employer or his insurance company agrees to the fact that the injury or disease was due to the employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employee.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Commission is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In those cases in which the physician appears as an expert witness for the injured employee, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employee through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Industrial Commission is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employee for payment. Likewise, where a physician treats an injured employee, and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Q. Are there special procedures for the handling of compensation claims of state employees?

A. In a sense, yes. The Commission is particularly explicit in its demands for itemized medical statements and for verification of the reasonableness of the medical charges in the case of state employees who file compensation claims.

Such cases require a report (on a form supplied by the Commission) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made.

In any case in which disability results or medical expense is involved, a statement is required from the employee (on a form supplied by the Industrial Commission) to the effect that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent

disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury occurred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employee's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employee has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Commission has adopted a guide table for disability due to losses of motion.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Commission worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder.*

Elements of disability include amputations, limitation of motion, pain, weakness, lack of endurance, and deformity. The disability is the percentage loss of use as compared to amputation at the affected joint or joints. When amputation is between joints, the loss is 100 per cent at the amputated joint, plus the percentage of bone loss at the next phalanx as determined by comparative x-rays. This is the loss for amputation and additional disability rating may be due for additional disability factors of the remaining portion of the limb. The Commission can determine the percentage of disability because of loss of motion from its guides, but the physician's opinion must be given as to the percentage of loss at each joint or joints that are affected for other elements of disability.

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. As the Commission has adopted these landmarks to measure disabilities only for loss of motion, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases

Industrial Commission Guide for Estimating Disabilities

The following guide represents per cent of loss of use as compared with amputations at involved joints. This guide measures disability for loss of motion only. Other factors of disability such as pain, weakness, loss of sensation, etc., are to be established separately.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Physicians should submit their reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and of professional fees to the physician.

should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Industrial Commission. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 31, since the Commission can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Commission has adopted special forms for use of physicians. If the Commission is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Commission?

A. Approximately 90% of all injury claims are paid by the employer or insurance company without dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Commission has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of certified or verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as the Commission may prescribe. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Commission has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Commission.

Q. Are there any suggestions for completing the forms required by the Commission?

A. The Commission needs a full report covering all factors if it is to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Commission to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. The law designates distal, second, and proximal joints. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. No standards or schedules not adopted by the Commission have the approval of the Commission. Only those adopted and published by the Commission itself should be considered as authoritative or as representing the Commission's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Commission has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employee, employer, Workmen's Compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Industrial Commission, Hill Farm State Office Building, Madison, Wisconsin.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation. Both the office of the State Medical Society and the Industrial Commission stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison, Wis. 53701, or to Mr. R. E. Gintz, Director of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Madison, Wis. 53702.

APPLICATION OF COMPUTERS MONOGRAPH IS AVAILABLE

A new volume, "Application of Computers in Cardiovascular Disease," fifth in the American Heart Association's Monograph Series, is now available through the Wisconsin Heart Association, 205 West Highland Avenue, Milwaukee, or the AHA national office at $2.50 a copy.

The publication reviews the use of computers in medicine, an area of great promise and of particular interest to research scientists, physicians concerned with medical records, and hospital laboratories.

Previous volumes in the Monograph Series including symposia on Congestive Heart Failure, Coronary Heart Disease, Angiotensin, and Use of Indicator-Dilution Technics in the Study of the Circulation.

ABORTION Protect Yourself

THE WISCONSIN Criminal Code provides a fine up to $5,000.00 or imprisonment up to three years or both for the intentional destruction of the life of an unborn child. The law states that an "unborn child" means a human being from the time of conception until it is born alive. If the life destroyed is that of an "unborn quick child" or of the mother, the imprisonment may be as high as 15 years.

A therapeutic abortion is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health. In an emergency the physician is permitted by statute to perform an abortion without the advice of two physicians, but he must be able to prove that the abortion was necessary to save the life of the mother.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

If you are called upon to treat a woman who has had an attempted or completed abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given, or
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

The above two steps are recognized by the Wisconsin Supreme Court as reasonable precautions before treating a woman who has had an attempted or completed abortion.

Abortion Deaths To Be Reported

Sometimes forgotten is the statutory requirement that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs.

Legal counsel for the Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. Pending clarification of this point by the legislature or the courts, the physician will do well to report *all* deaths associated with abortion.

REFERENCES

1. Wisconsin Statutes, 1961, Section 940.04
2. Wisconsin Statutes, 1961, Section 966.20
3. *State v. Law* (1912) 150 Wis. 313

1962 FEDERAL INCOME TAX NOTES

Three amendments to the federal Internal Revenue Code, enacted in October, 1962, hold special interest for many physicians for the tax year 1963. They are:

1. New provisions relating to travel and professional entertainment expense deductions for income tax purposes.
2. The deduction from the tax otherwise payable of an investment credit for new business or professional property purchases. Does *not* apply to real estate.
3. Elimination of capital gains treatment on disposition of property used in business or profession, other than real estate.

In addition, the Treasury Department, by revenue ruling, has set out new guide lines for depreciation allowances, intended to permit more depreciation per year through the adoption of shorter lives on various types of buildings and equipment.

The investment credit provision is retroactive to January 1, 1962. The ruling on depreciation allowances is effective for all returns due after July 11, 1962. The other two items have an effective date of January 1, 1963.

Physicians will do well to take up the above points with their tax accountants and attorneys because of their frequent applicability to medical practices and to the ownership of equipment or real estate used in such practices.

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach the subject. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The legal right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

THE WISCONSIN statutes and court interpretations are controlling on who may use the title "doctor" when "treating the sick."

The following is a summary of the present law of Wisconsin as it applies to use of the title "doctor" when engaged in "treating the sick." This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 147.01 (1) of the Wisconsin Statutes, 1961, provide:

> "(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.
>
> (b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 147.14 (3), Wisconsin Statutes, which provides:

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use	No Right to Public Use When Treating Sick
1. Physician	X	
2. Osteopath	X	
3. Dentist	X	
4. Podiatrist (Chiropodist)	X	
5. Chiropractor		X
6. Optometrist		X
7. Doctor of Philosophy (when treating the sick)		X

"(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D.," "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 152.02 (1), Wisconsin Statutes, which provides in part:

"(1) Any person who was lawfully engaged in the practice of dentistry in this state on January 1, 1939, may so continue if he has registered annually. . . . No other person shall practice dentistry in this state, unless he is licensed by the board and annually registered in this state. . . . Any person is deemed to be "practicing dentistry" within the meaning of this chapter who . . . uses or permits to be used, directly or indirectly, for a profit or otherwise for himself, or for any other person, the title or appends to his name the words or letters "doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," or "D.M.D.," or any other letters, titles, degrees, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry. . . ."

4. **Podiatrist:** (Chiropodist) The right of a registered podiatrist to use the title without restriction is conferred by Sec. 154.01 (2), Wisconsin Statutes. This provides in part:

"(2) No person shall practice podiatry, for compensation, directly or indirectly, or in the expectation thereof, or attempt to do so, or designate himself as a licensed podiatrist, or use the title "D.S.C.", "Dr.", or 'Doctor of Surgical Chiropody", or "Doctor of Podiatry", or "Doctor", or "foot doctor", or "foot specialist" or other title or letter indicating that he is a podiatrist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the state board of medical examiners . . ."

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 147.14 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels* (1938) 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the use of the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903, osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O. D." in the course of his practice. Chapter 153 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 147.14 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Doctor of Philosophy:** There is no Wisconsin court decision authorizing *any* doctor of philosophy, including a psychologist, to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 147.14 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932) 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 147.14 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

How to Complete a Death Certificate

The death of a patient requires at least one legal act by the physician. How he does it can be very important.

MOST death certificates are made and signed by a physician. The reason is obvious—most deaths occur with a physician in attendance. This final act by the physician is not a mere routine.

A death certificate is vital in a number of ways. In Wisconsin a human corpse may not be buried or otherwise disposed of before a proper death certificate is made and signed by a competent person. Burial may not take place without a permit for burial or removal. Issuance of the permit depends on a "complete and satisfactory certificate of death."

Here is what the law requires:

1. The certificate shall be made and signed by the physician last in attendance on the deceased.
2. The certificate must specify the time in attendance, the time the physician last saw the deceased alive, and the hour and the day at which death occurred.
3. The physician must state the causes of death in such a way to show the course of disease or sequence of causes resulting in death, and the duration of each.
4. Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from disease are not acceptable. A certificate containing only such terms will be returned to the physician for correction and definition.
5. The causes of death which may be the result of either disease or violence must be carefully defined. If violence is the cause of death, its nature should be stated, as well as whether it was accidental, suicidal, or homicidal.
6. In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required and state where, in his opinion, the disease was contracted.
7. The cause of death and any other facts required must be stated in accordance with the rules and regulations of the State Registrar.

Whoever makes and signs the death certificate must be acquainted with the facts. There may be instances in which the physician last in attendance does not know the cause of death. He may not possess all the information needed to complete a certificate. As a rule, the attending physician does not find it necessary to make a special investigation in order to prepare a certificate. But when a physician is called in to prepare a certificate for a patient he was not attending, he should not insert the information required without first making whatever investigation he feels necessary.

The local registrar may make and sign the certificate if all three of the following conditions are fulfilled:

1. There have been no attending physicians
2. The person desiring to dispose of the body has made request for a burial or removal permit
3. It is impossible to obtain a physician to investigate the cause of death and prepare and execute the certificate "early enough."

"Early enough" has not been officially interpreted, but it probably means that the local registrar may act in order to prevent an unreasonable delay in funeral ceremonies. If all three conditions are fulfilled, the registrar may make and sign the certificate, utilizing information supplied by relatives of the deceased or other competent lay persons. However, if a physician *may* be obtained he *must* be obtained. Such a physician's services will be paid for by the person seeking disposition of the body. Payment of the physician is reimbursable from the estate of the deceased person as a proper funeral expense.

The coroner may issue a certificate of death:

1. If he has held an inquest on the body
2. Without a formal inquest, if he has investigated a death falling in any of the following specific categories:
   a. Death occurring in a hospital, sanatorium, public or private institution, convalescent home, or the like
   b. Death under unexplained, unusual, or suspicious circumstances
   c. Homicide
   d. Suicide
   e. Death following an abortion
   f. Death due to poisoning, whether homicidal, suicidal, or accidental
   g. Death following accident, whether the injury received was the primary cause of death or not
   h. Death when no physician was in attendance
   i. Death when a physician refuses to sign the death certificate.

REFERENCES

1. Wisconsin Statutes, 1961, Section 69.38–69.41.
2. Wisconsin Statutes, 1961, Section 69.44 (1).
3. 40 O.A.G. (1951) 476.

Professional Liability

Prevention and Insurance

THERE IS no guarantee that sometime, sooner or later, you will not be faced with a malpractice suit, whether justified or not. How you react and the precautions you took beforehand may save your reputation, protect your pocketbook, and stave off nuisance suits.

A. PREVENTION

1. Be Alert

Watch your patient's emotional and psychological reactions. Answer his questions in a sympathetic and reassuring manner. Be alert to dissatisfaction, grumbling, and uneasiness of the patient and his family.

2. Keep Thorough Records

Record everything medically relevant concerning a patient. Your records give you a place where you can point and say with confidence—"I know I advised my patient correctly—here is proof." A few minutes spent dictating a letter to a patient (with a copy for your files) may save many hours later.

3. Seek Consultation When Indicated

An opinion of another physician in a difficult case shows not only that it was difficult but also that you did not rely solely on your own judgment. It is easier to show your patient or his family afterwards that you examined every practical alternative before treatment.

4. Don't Panic—Just Listen

When the complaint or accusation is made, there is a strong temptation to defend yourself, argue, alibi, explain, or even retaliate. *Don't do it.* Just listen carefully and be thankful you are getting advance notice so you have time to prepare.

5. Speak With Extreme Caution

Anything you say may be held against you. Not long ago a patient threatened a Wisconsin physician with malpractice when her "sprained knee" turned into a long-term disability. Confronted in his office by the patient, the physician did a quick recheck of the situation and replied, in effect, "You're right. If I'd taken a couple of follow-up x-rays three months ago, we would have caught it." This admission was "manna from heaven" to the patient. Whether or not the physician's treatment had been good medical practice, his impromptu remark was an admission against his own interest and he thereby forfeited any defense he might have had. The case was settled out of court.

6. Be Quick To Notify Your Insurance Carrier

As soon as you suspect a malpractice suit in the making, notify your malpractice insurance carrier *immediately.* Also get private legal counsel. Don't wait. Any delay may be disastrous to the preparation of a defense. Adequate defense in the unjust malpractice case is a difficult task. Physicians with little or no knowledge of the law are obviously out of place in attempting to defend themselves. Lawyers with little or no medical knowledge or experience in malpractice cases are not in a position to help you. In the face of a suit, you will be wise to find expert legal advice.

7. Be Slow To Compromise

Don't be too quick to settle. Many physicians operate on the theory that a small settlement will be less expensive than the cost, publicity, loss of time, mental and emotional strain involved in the defense. Experience shows that unjust and absurd malpractice claims double and triple in areas where physicians are found to be a "soft touch." An increased number of malpractice claims and higher insurance rates can be a direct result of the "settle-it-quick" attitude on the part of some physicians. For your sake and that of your colleagues, you should offer determined opposition to any unjustified claims.

8. Collect Your Defenses

At the slightest possibility of a claim, begin to pull together your records, reports, and other evidence which might be required for your defense. *At this point, every shred of recorded evidence becomes mighty important.* But in *no* case should you fill in or otherwise *alter* your existing records in any way.

9. Settle a Meritorious Claim Out of Court

The physician who is actually guilty of malpractice is not likely to go free of penalty. Let your conscience, not alone your pride, be your guide. Meritorious claims should be settled out of court—preferably *before* a suit has been filed. But never settle without having competent legal advice.

B. PROFESSIONAL LIABILITY INSURANCE

If you are ever sued for malpractice, you will need a good professional liability insurance policy, as well as a good defense. Such a policy assures you competent legal advice in the evaluation of your case, preparation of your defense, negotiation of a settlement, where appropriate, and payment of a verdict should one be rendered against you. Ex-

perienced counsel will usually recognize and deal effectively with a groundless claim.

Among the specific elements of an adequate professional liability policy, or questions you need to have answered before knowing that you have adequate coverage, are the following:

1. Is your insurance company well established in the malpractice area?

The State Medical Society and your personal attorney are in a position to answer this. The question is important because the adult you treat may wait for three years before he starts a lawsuit alleging malpractice in your treatment of him today. The infant you deliver today may start his action as late as the date before his twenty-second birthday. The patient who is under mental disability today, or goes under guardianship within the next three years, may have up to a total of eight years in which to determine whether to sue for today's services.

You must also remember that the company that insures you *today* is the company that contracts to protect you when you are sued, and *not* a different company whose policy you may hold at that time.

2. Are your policy limits high enough?

You can never be sure of striking a balance between premium economy and adequate policy limits, but it is better to have more insurance than you need than to need more insurance. Your policy has two types of coverage. The first type assures you of legal investigation and defense of a claim, if you have observed the requirements of the policy. The other pays the amount of damages up to the stated limits of the policy if you are found liable or if you settle the claim.

3. Does your policy allow you, without penalty, to reject a claim settlement which seems expedient to the company but not to you?

The necessity of such a provision in your policy depends on which of two considerations is more important to you. Do you want the claims against you settled or do you want your reputation defended? Even if your policy does give you the power of rejection you must exercise it with restraint based on competent advice since you must also consider the greater damage to your professional reputation if you lose at trial.

4. Does your policy protect you for all the procedures and forms of treatment you use in your practice, and does it cover claims based on defects in any apparatus you use?

Have your personal attorney check your policy for exclusions against any of the above. If you do find gaps, you can probably buy additional coverage for additional premium to cover those areas. If a particular company won't issue higher limits to you, a second company may be willing to do so.

5. Does your policy cover your acts which, though outside the immediate scope of your practice, are within the general area of your professional competence and activity?

For example, you may be a proprietor, administrator, or trustee of a hospital. If your policy excludes coverage for such risks, you may want an endorsement or new policy. If you are engaged in some activity where there is doubt in your mind about coverage, the prudent course is to give your insurance company written notice describing the activity and requesting a written commitment which covers or rejects such risk.

6. Does your policy protect you against claims based on acts of other persons?

Not only your own acts, but also the acts of employees or partners, may give rise to malpractice claims against you. *You* will want to make sure that your policy protects you no matter *who* commits the act.

7. Does your policy let the company decide the question of coverage when a claim accuses you of misconduct which, if proved, would not only establish the claimant's case against you but also relieve the company of any legal responsibility to you?

Probably no policy language is completely satisfactory in the area in which the company is able to deny coverage for defense of a suit prior to a verdict. Such a denial would amount to a presumption of your guilt pending proof of the charges of professional misconduct. It is most important that you have independent legal counsel of your own, and not rely entirely on your insurance company. In this area your interests and those of your insurance company can be in serious conflict.

8. Finally, are the "declarations" in your policy correct?

Your needs may differ from those of some other physicians. The declarations in your policy not only state your name, the fact that you are a physician, and the cash limits of the company's liability, but also *may* contain some detail about the manner in which you practice. To the extent that they do, they describe the risk that your company agrees to insure. If there is a discrepancy between the facts and what the "declarations" state, you may find you have no coverage when a claim arises. Therefore, any errors or discrepancies you find should be corrected immediately. Further, any time your practice changes, your declarations should also be revised as needed.

In conclusion, the steps you take *now* to prevent malpractice claims, or to have a professional liability policy which adequately meets your needs, will pay off in the future in a saving of time, money, worry and, above all, your professional reputation.

Locum Tenens

For a variety of reasons a physician may have occasion to leave his practice for an extended period of time. The choice of the interim custodian of his practice and the arrangement under which he carries it on are then of very real importance. They call for more than a telephone call and a handshake.

IN THOSE cases where a locum tenens is secured, the State Medical Society urges that the arrangements be confirmed by a written contract, drawn with the assistance of a local attorney. In arriving at the terms of such an agreement members should consider these fundamental points:

Licensure

The locum tenens must be licensed in Wisconsin to practice medicine and surgery. Membership in a local and State Society is further assurance of his ethical standing and professional qualifications.

Staff Privileges

Association on the hospital medical staff, where necessary, should be arranged. The locum tenens should be apprised of the conditions necessary to a continuation of this association, and his compliance with them should be a continuing condition of the contract.

Malpractice Liability

Malpractice insurance should be maintained by both parties under all circumstances.

Legal Relationship

One of the most important matters for decision is that of determining the relationship under which the locum tenens is to assume management of the office. It is important to both parties whether the locum tenens is an independent contractor, an employee or appears to be, or in fact is, a partner. Not only general law but such special stautes as that relating to fee splitting must be taken into account.

Your own attorney can best describe the practical aspects of this problem. It is sufficient to say that there is a real distinction between these with respect to liability of the principal party for the acts of the locum tenens, and with respect to his power to bind or otherwise obligate his absent confrere. In deciding this relationship, consideration must necessarily be given to the extent the locum tenens is to control the practice. For example, may he move the office acting upon his best judgment alone? Are the costs of operation to be a joint burden, and in any event, what are they?

Financial Arrangements

Whether the locum tenens is reimbursed on a salary, drawing or other basis, arrangements must be made with respect to handling withdrawals, the financial records to be kept, collection policy and obligations of the locum tenens with respect to accounts receivable of the physician.

Locum Tenens to Give Entire Time

As an essential provision of the contract, provisions should be made with reference to the amount of time that the locum tenens is to devote to the practice. Is he to give his entire time and not to engage in any business which would detract from his abilities to serve the community professionally?

Costs of Operation

If the salary or drawing arrangement with the locum tenens is to be based on the percentage of net income after payment of operating costs, items of costs should be specified so nearly as can be determined. If the physician should own his own office, it is only proper that a rent basis for use of the office be established, and such items as light, heat, wages, insurance, supplies and equipment and the like should all be taken into consideration.

The physicians must likewise determine their policy with reference to accounting for collections for services rendered prior to execution of the agreement by the departing physician. Are these to be considered income under the contract or are they excluded?

Restriction on Practice After Termination of Agreement

Wisconsin recognizes the validity of clauses restricting practice after termination of a contract of employment. Your attorney may refer to the Wisconsin Statutes (1961) Section 103.465 and the case of *Lakeside Oil Company, Inc. v. Slutsky* (1959) 8 Wis. 2d 157 and the cases cited in the latter. The rule in Wisconsin requires that a restrictive covenant not to compete after a term of employment should be reasonably necessary for the protection of the legitimate interests of the employer and at the same time should not be oppressive and harsh on the employe or injurious to the interests of the general public. An unreasonable restraint is void and unenforceable even to those parts of the restraint which would constitute a reasonable restraint.

Therefore, great care should be taken when drafting such a clause so as to make the restraint fit within the Wisconsin rule.

Termination

A provision for termination of the contract should be made. At the option of the party a definite date may be selected or termination can depend upon the time when the absent physician returns, or may be of indefinite duration, and terminable upon sixty or more days' notice. In any event it should be stated that failure on the part of the locum tenens to carry out in good faith the provisions of the contract should be cause for termination without notice.

Miscellaneous Matters

Other matters which a physician may desire to pass upon may include questions concerning the handling of certain business and personal matters of the absent physician, as well as the form of stationery, billing head, prescriptions, liquidation after termination of the agreement of accounts receivable arising during the operation by the locum tenens of the practice, care and replacement of medical instruments and the like.

POISON INFORMATION CENTERS

MADISON • Phone 262–3702

Call University Hospitals, ALpine 6–6811, and ask for "Poison Center" for information concerning any substance suspected of being poisonous.

MILWAUKEE • Phone 344–7100

The Poison Information Center in Milwaukee was established in 1956 through the efforts of The Medical Society of Milwaukee County Subcommittee on Accident Prevention. It is located in Milwaukee Children's Hospital.

EAU CLAIRE • Phone 832–6611

The Poison Information Center for physicians in the Eau Claire area is located at Luther Hospital.

GREEN BAY • Phone 435–5311

For physicians in the Green Bay area, the Poison Information Center is located at Bellin Memorial Hospital.

KENOSHA • Phone 654–5311

The Poison Information Center for physicians in the Kenosha area is located at Kenosha Hospital.

The Poison Information Centers maintain complete information on poisons by commercial name, ingredients, relative toxicity and treatment procedures. Their files are kept current through periodic releases received from the Clearing House for Poison Control Centers in Washington, D.C.

Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow will also be presented with the problem of what to do with the physician's narcotics. The Acting District Supervisor of the Bureau of Narcotics of the U. S. Treasury approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Special Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused order forms should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin. The narcotic drugs may be disposed of by shipment, charges prepaid (shipments by mail shall not be made) to the District Supervisor, Federal Bureau of Narcotics, 817 New Post Office Building, Chicago, Illinois 60607, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs."

It is important that a widow, other members of the family and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

Responsibility of the Physician Conducting Pre-Employment Examinations

PHYSICIANS express increasing interest in their legal responsibility to offer or withhold information following a pre-employment physical examination. The subject has been considered by the general counsel for the Society and the substance of his opinion follows.

Question. What are the responsibilities of a physician to an employer for whom the physician is doing pre-employment physical examinations, to reveal to the employer conditions known to the physician to exist (such as epilepsy) but of which the physician would have no knowledge in the course of the examination except by previously acquired information in his capacity as the examinee's personal physician?

Answer. Unless the examinee authorizes the physician to disclose to the employer information acquired by the physician in his professional capacity as the examinee's personal physician, the physician should make no such disclosures to the employer.

Opinion. At first sight this question may appear to present a dilemma, but it does so only if the physician and employer have failed to define the physician's responsibilities with sufficient clarity. It should be made clear to the employer at the outset that the physician will limit his reports to such facts as are revealed to him during the examination itself, and will not include information acquired by the physician while treating the examinee as a patient.

The physician to whom this situation is presented is quite likely to feel disturbed by two apparently conflicting legal obligations:

(1) His statutory and ethical obligation to his patient to refrain from "willfully betraying a professional secret;"
(2) His contractual obligation to the employer to disclose all he might know that bears on the prospective employee's fitness for a particular job.

Actually, the physician has only the first of the above mentioned legal obligations. Even if his contract with the employer contained a specific provision requiring the disclosure without the patient's consent of information acquired in the course of professional treatment, that provision would undoubtedly be held void by any court passing upon it, as being contrary to the public policy implied in the protection of secrecy afforded by Section 147.20 (1) (d) of the Wisconsin Statutes.

The real problem, therefore, is not a legal one. Rather, it is a problem in communications. The employer, quite possibly unfamiliar with the physician's legal and ethical obligations to his patients, might find it difficult to understand how the physician could be so lacking in candor as to fail to disclose all information for which the employer may feel he has contracted. The obvious solution to this problem of communication is to inform the employer, preferably at the time of contracting, that the physician's reports will cover only the information obtained at the time of the physical examination made at the employer's request. If this was not made clear to the employer at the time the physician and employer originally contracted for the pre-employment examinations, the physician would do well to clarify the arrangement at a later date, being careful, of course, to refrain from doing so in such a manner or at such a time that the employer would be likely to suspect that one particular employee had a serious health problem.

Another solution, more drastic than is really necessary, would be for the physician to exclude from the list of those on whom he would make pre-employment physical examinations, all persons who had previously consulted him as patients. Such a solution is recommended only if the physician, in making such examinations, finds it difficult to conduct the examination as if he did not know what actually he does know from prior diagnosis or treatment.

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service or moving to Wisconsin from another state *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to criticism or disciplinary action.

Temporary licenses may be granted under special circumstances by the State Board of Medical Examiners. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

Reference: Sections 147.14(1), 147.15(2), 147.19, Wisconsin Statutes, 1961.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 966.121, Wisconsin Statutes, 1961.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 325.23, Wisconsin Statutes, 1961.

DO YOU EMPLOY FOUR OR MORE PERSONS?

If you do, then you must pay unemployment insurance taxes.

Employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to both the state and federal unemployment insurance tax.

The combined standard state and federal tax is 3.1% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.4% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

If a physician or clinic has employed four or more persons in any portion of each of 20 weeks during the current year and has failed to pay the quarterly payments to the state, this should be done promptly so as to keep at a minimum any penalties and interest which will be due. Payment of the annual federal unemployment insurance tax is due by January 31.

Guide to Organization and Operation of Airport Medical Services

THIS GUIDE deals with medical services for civil airports only.

An airport is a facility which often consists of an aggregation of industrial, business, and commercial establishments, governmental as well as private, collectively engaged in the air transportation of people and goods. The operation and logistical support of this facility usually include the maintenance of the aircraft and other equipment, the "maintenance" of its operating and service personnel, and the ministration to certain needs of passengers, visitors, and others of the airport population.

Airports vary so greatly with respect to size and traffic volume, the distances from communities served, and the size and character of those communities, that no single statement for the provision of airport medical service could apply to all airports. Accordingly, this statement is limited to principles which should serve as a guide to the establishment of adequate medical services. The needs and problems of each airport are sufficiently different as to require a program of medical services tailored to its specific needs.

General Considerations

Airports are usually classified in 2 major categories: Those primarily for the use of commercial carriers, called *commercial airports*, and those primarily or exclusively for the use of private or business aircraft or both, called *general aviation airports*.

The *commercial* airports are usually owned and managed by municipalities or port authorities. *General aviation airports* may be owned and operated by cities, counties, states, individuals, or corporations. In 1962, only about 10% of the some 6,000 airports in the United States were commercial airports.

A large commercial airport may cover an area of 100 square miles, with many different kinds of buildings, with 5,000 or more employees of 50 or more employers, serving the needs of 3 million or more passengers and a like number of visitors each year. Some of the smallest airports consist only of an open field, owned by one person, and merely a small shed, a gas pump, and tie-down facilities.

Thus, on the premises of airports, there are persons who require or may require health and medical services of different kinds, e.g., occupational, public health, and aviation medical services in addition to first-aid and emergency medical care. Moreover, medical assistance is required in crash-rescue operations and in the investigation of aircraft accidents.

The provision of medical services to meet the requirements of airports is beset with many problems which are peculiar to these varied conditions. For example, in most airports the individual employee groups are not large enough to require or justify having their own occupational health program. Moreover, airports are visited by the public, numbering millions a year in the cases of the largest airports. The responsibility for providing the public with needed health services on the airport premises has not been clearly delineated or assigned. Furthermore, accidents, including airplane crashes, do occur and require emergency medical and other rescue operations. In general, responsibility for such rescue operations has been assumed by airport authorities. The airlines, the Federal Government, and the local communities also have considerable interest in ensuring the promptness and adequacy of such operations.

This document, supplementing the following American Medical Association statements, provides guidance for the organization and operation of an airport medical service.

"Scope, Objectives and Functions of Occupational Health Programs," "Guide for Industrial Immunization Programs," "Guiding Principles of Medical Examinations in Industry," "Guide to the Development of an Industrial Medical Records System," "The Survey of the Occupational Environment," "Guide for the Development of Medical Directives for Occupational Health Nurses," "The Legal Scope of Industrial Nursing Practice," "Medical Criteria for Passenger Flying—Scheduled Commercial Flights," and "Medical Relations in Workmen's Compensation."

Definitions

For convenience, brevity, and uniformity, the following terms are used in this guide:

Airport Authority.—The administrative body having responsibility by law, charter, incorporation, or

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This guide was prepared by the Committee on Airport Medical Services, a subcommittee of the Committee on Aerospace Medicine of the Council on Occupational Health. Members of the Committee were: William F. Ashe, M.D., Chairman; Charles I. Barron, M.D.; Lt. Col. F. L. Bowling, M.D.; Ludwig G. Lederer, M.D.; Homer L. Reighard, M.D.; Harry D. Vickers, M.D.; and Henry F. Howe, M.D., Secretary. The guide was approved by the House of Delegates of the American Medical Association at the 111th Annual Meeting, Chicago, June 27, 1962.

Henry F. Howe, M.D.,
Secretary,
Council on Occupational Health

Reprinted with permission from the *Journal of the American Medical Association*, Vol. 182, pp. 957–960, December 1, 1962. The guide also was reprinted in *Aerospace Medicine*.

otherwise for the operation of a public-use civil airport.

Airport Medical Facility.—The physical facility or facilities located on an airport, equipped and staffed to provide medical services to the airport population.

Airport Premises.—The entire area of an airport and all structures thereon.

Airport Population.—All persons on the airport premises at any given time.

Airport Tenants.—All city, county, state, and Federal governmental agencies; all airlines and other industrial, commercial, and business concerns; and all other groups that are represented, i.e., have employees on the airport premises. The airport authority may itself also be a tenant.

Civil Airport.—An area of land adapted to and primarily intended for the landing and taking off of civil (nonmilitary) aircraft. It includes all structures, facilities, and improvements located on the land designated as the airport.

Contractors for Medical Service.—Those airport tenants who contract for medical services.

Medical Advisory Board.—Physicians serving as individuals or as representatives of medical organizations or institutions to advise the airport authority on the establishment and operation of an airport medical service.

Medical Director.—The physician directly responsible for the operation of the airport medical service. He may be paid a salary and may work full time in the airport medical facility. He may be under contract to the professional service contractor, unless, as sometimes is the case, he *is* the professional service contractor.

Professional Service Contractor.—The physician, group of physicians, medical organization, or institution under contract with the airport authority to provide professional services as a part of the airport's medical service.

Pertinent Considerations

An airport medical service should have a written, tested emergency plan with provision for adequate communications to assure medical coverage as needed. In addition:

1. Airport tenants should provide for their employees occupational health services on the order of those recommended in the American Medical Association's statements on "Scope, Objectives and Functions of Occupational Health Programs."

2. Emergency treatment should be available at the airport for cases occurring among the airport population of such urgency that to send the patient to an outside facility would endanger life or limb or unduly increase or prolong suffering.

3. Adequate medical participation should be provided at any time in the rescue and emergency treatment of victims of an aircraft accident.

4. Persons among the airport population who are required by local, state, or Federal regulations to pass medical examinations for various purposes, e.g., food handlers, barbers, and travelers subject to immigration, should be able to obtain such examinations with the promptness required and with a minimum of expense and inconvenience.

5. Aviation medical services should be available to include medical examination and surveillance of airmen, the rendering of advice concerning persons flying, and consultation to the airport authority and tenants on aeromedical problems.

6. The interests of local physicians should be considered in any arrangement for the provision of medical services to airport populations.

Support from the Military

Local airport disaster plans should contain provisions for complementary assistance from nearby Army, Navy, Air Force, and Coast Guard installations. Military hospital services would normally not be provided in areas where civilian hospital facilities are available.

Planning and liaison with military establishments should be in accordance with the following directives:

Department of Defense Directive No. 3025.1, "Responsibilities for Civil Defense and Other Domestic Emergencies," dated 14 July, 1956, as amended.

Joint Chiefs of Staff, JCS Pub. 2, Section 5, November, 1959; Chapter V, Section 8, Page 93, JCS Pub. 3, "Civil Defense and other Domestic Emergencies," December, 1961.

Air Force Regulations (AFR) 55–37, "Military Assistance in Domestic Emergencies," 10 Sept., 1958.

AFR 355–3, "Disaster Control," 12 Aug., 1960.

AFR 160–73, "Persons Authorized Medical Care," Paragraph 35, 15 May, 1957.

AFR 160–88, "Medical Responsibilities in Disaster and Modern Warfare," 15 Aug., 1958.

The agency responsible for investigation of civil aircraft accidents is the Civil Aeronautics Board, with liaison and assistance from the Federal Aviation Agency. Arrangements for provision of consultation services of the Armed Forces Institute of Pathology in the investigation of aircraft accidents have been made with the Civil Aeronautics Board and the Federal Aviation Agency. Such services may be obtained in exceptional cases upon request of the Civil Air Surgeon in the investigation of light aircraft accidents. These services are available to the Civil Aeronautics Board when requested for the investigation of accidents involving air carrier aircraft.

Support from Public Health Departments

Airport medical services may be augmented through local health departments. As a general guide for planning, reference is made to the publication, "The Local Health Officer in Occupational Health," Department of Health, Education and

Welfare, Public Health Service, obtainable from the United States Government Printing Office, Washington 25, D.C. This publication covers the activities of physicians, nurses, engineers, chemists, sanitarians, health educators, and others. Generally, public health departments are available to assist in identifying and controlling an occupational health hazard or an industry-related community health problem, as well as in advising industry in the establishment of employee health programs. Public health officials, either local or state, usually can and will provide advice and industrial hygiene services.

Support from Community Disaster Programs

Many communities have relatively well-developed medical disaster plans. Disaster plans for airports should be coordinated with these programs. Local coroners or medical examiners should arrange with pathologists for adequate postmortem examinations in keeping with the procedure outlined in the Armed Forces Institute of Pathology Manual, "Aircraft Accident Investigation." Members of medical staffs of local hospitals should be prepared to determine the blood levels of alcohol, barbiturates, and carbon monoxide of individuals involved in aircraft accidents, nonfatal as well as fatal.

Patterns of Organization of Airport Medical Service

A few of the several possible patterns of organization of an airport medical service follow. They are included only as suggestions which may be of help to those who must participate in development and operation of adequate medical programs at local airports. (1) A cooperative plan initiated and administered by airport tenants; (2) a private medical group operated at the airport as a concession; (3) operation of the airport medical facility by physicians employed by the airport authority; and (4) provision of physician's and nurses' services by a physician or group of physicians or medical organization under contract with the airport authority.

Initiation of Airport Medical Service

Efficiency and economy may be improved by the pooling of medical service monies, personnel, equipment, and supplies.

The airport authority, by virtue of its broad administrative control, is in a position to determine and specify the services of all types which will be established at an airport.

In order to insure the adequacy of plans for establishment and operation of the medical service, the airport authority should seek advice from appropriate local medical sources, such as medical societies, health departments, medical institutions and specialists in aviation and occupational medicine, and from nationally recognized authorities in these fields.

Two important considerations in planning and administering such a service should be recognized at the outset. First, duly licensed local physicians should be provided an opportunity to participate in the planning and development of airport medical services. Second, since coordination of effort is required to insure the effectiveness of the program and since a medical director is expected to effect and maintain this coordination, he must have authority and freedom to act commensurate with this responsibility.

The airport authority should invite the local medical society to nominate representatives to serve on a medical advisory board to assist it in planning and operating a medical service.

Any agreement between the airport authority and the professional service contractor should guarantee to the latter the necessary latitude to establish and operate medical services commensurate with the airport's specific needs.

Staff and Equipment

The nature of the professional services rendered at larger airports makes it advisable to consider a specialist in aviation or occupational medicine or both for appointment as medical director. In addition to his specialty qualifications, the director must be licensed to practice medicine in the state and, in order to assure the needed cooperation of the medical community, be eligible for local medical society membership. Should circumstances warrant, he may serve as a full-time, salaried physician and not engage in the private practice of medicine, either at the airport or elsewhere.

Additional staff physicians should be specialists or have interest and competence in aviation or occupational medicine or both, in addition to appropriate licensure and eligibility for local medical society membership.

Staff nurses should meet the professional qualifications recommended by the American Medical Association statement, "Guide for the Development of Medical Directives for Occupational Health Nurses."

Additional professional staff such as industrial hygienists should demonstrate the professional training and experience appropriate to assigned responsibilities.

Professional staff members may be under agreement with and receive payment from the professional service contractor and should be under the professional and administrative supervision of the medical director.

Administrative, clerical, and technical personnel, although under the direct supervision of the medical director, may be the employees (for administrative and pay purposes) of either the contractor for professional services or the airport authority.

The manner of providing space, equipment, supplies, janitorial service, and utilities is expected to vary with the airport and with the professional service contractor.

Financing

The airport medical service may be financed with funds from several sources, e.g., (1) airport authority; (2) contractual arrangements with ten-

ants for occupational or aviation medical service or both; (3) fees for services rendered to the general public and to employees not covered by contract; and (4) fees for Federal Aviation Agency certifying examinations.

Airport tenants (employers) may not be legally bound or consider themselves morally bound to provide their employees with occupational health services. Therefore, the degree of participation by tenants not already participating in the financial support of an occupational health program will depend on the extent to which they are convinced of the value of such a program. The actual establishment and operation of a good occupational health program probably offers the most effective demonstration of its value.

Except when operated as a concession, the medical service would operate as a nonprofit enterprise. Monies received in excess of those required for staffing, consultation, supervision, and operation should be used for improvements in facilities and service or adjustments in payment required of contracting tenants, or both. The medical advisory board would be expected to advise the airport authority on disposition and distribution of income in a manner to insure effectiveness and solvency of the program.

The professional service contractor should be responsible for maintaining a system of accounting which would demonstrate the appropriateness of charges adopted. The schedule of charges would be subject to review by the airport authority, with the advice of the medical advisory board. The schedule of charges would also be specified in contracts for service to tenants and would, therefore, be subject to their individual review.

Although the professional service contractor (and the medical director) should participate in discussions with tenants concerning services to be rendered and in developing the terms of a contract, the contract for medical service itself would frequently be made between the airport authority and the tenant. The airport authority may have to be in a position to guarantee fulfillment of the contract and to handle the legal and administrative details involved.

Insofar as practicable and feasible, a contract should be negotiated with each tenant, in order to permit maximum tailoring of the services to meet each tenant's needs. However, certain basic features should be included in all contracts. It might be possible and desirable to require that certain minimum essentials of an occupational health program be provided in all contracts. Tenants without a contract would then be served on a fee-for-service basis, involving usually a higher unit charge.

Small Airports

Obviously, there are large numbers of smaller airports, both commercial and general-aviation, in which no elaborate medical facilities are needed. There are, however, basic requirements applicable to all airports. These are: (1) a medical advisor; (2) a tested communications system which will summon medical aid as needed; (3) a written, tested accident emergency plan with provision for adequate communications to assure medical coverage as needed; and (4) a written, up-to-date, tested general disaster plan.

As the facility adds water and toilet facilities and food services, the public health considerations come into play.

As the airport reaches a size requiring full-time employees, arrangements should be made for preplacement and periodic physical examinations and for the treatment of injuries. Local certified FAA medical examiners should be utilized for aviation medical services and as consultants to the community at large on matters of aviation medicine, including the investigation of aircraft accidents. Public health officials, either local or state, usually can and will provide advice and industrial hygiene services. Local coroners should arrange with pathologists for adequate post-mortem examinations in keeping with the procedures outlined in the Armed Forces Institute of Pathology Manual, "Aircraft Accident Investigations." Local hospital personnel should be prepared to determine the blood levels of alcohol, barbiturates, and carbon monoxide of individuals involved in aircraft accidents, nonfatal as well as fatal.

THIRD ANNUAL CANCER CONFERENCE FOR NURSES

"CANCER AND CARE OF THE PATIENT"

Sat., Mar. 21, 1964—9:30 a.m. to 4:00 p.m.—Wisconsin Center—University of Wisconsin Campus—Lake at Langdon

Co-sponsors: University of Wisconsin Medical Center's Division of Clinical Oncology and American Cancer Society, Wisconsin Division.

Special guest speaker at 12:30 luncheon: Miss Catherine Nelson, R. N., Columbia University Teacher's College, Department of Nursing Education, New York City—one of the nation's best nurse teachers and speakers according to the program chairman, R. J. Samp, M. D.

Registration fee $3.00 (covers luncheon). Contact R. J. Samp, M.D ., Box 1626, Madison, Wis. 53701.

The Society's Placement Service Aids Physicians and Communities

ONE OF THE many functions of the State Medical Society is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

At the end of November 1963 there were 111 opportunities listed with Placement Service. Twenty-one of these have requested the services of specialists. The current list of interested physicians includes 27 general practitioners and 112 in specialties.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities, and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Approximately 17 openings were filled during the first eleven months of 1963; and 47 other physicians located in Wisconsin, many of them through the assistance of Placement Service.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Physicians' Exchange" section of the *Wisconsin Medical Journal.* This is a classified advertising section which is available to individual members of the State Medical Society without charge; and is also available to communities, clinics of four or more physicians, and others at a reasonable charge.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. Journal advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701; and/or Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

State Laboratory of Hygiene Offers Quality Control Program in Clinical Chemistry

The State Laboratory of Hygiene announces a cooperative quality control program in clinical chemistry available to all laboratories in the state. At the outset unknowns of glucose will be shipped in the first week of each month to each laboratory. The results are returned to the State Laboratory of Hygiene who will summarize them, indicating the participating laboratories by code number only and return a summary graph to each individual. The results of the four reference laboratories will be indicated; these are the State Laboratory of Hygiene, The University Hospital Laboratory, the Bioscience Laboratory, and the Biochemical Procedures Laboratory. Usually two unknowns will be shipped monthly, one in the high range and one in the low. As of the present writing 43 laboratories are participating. There is no charge connected with this service. Other tests will be added in the future.

A quality control service such as this would seem of special importance to chemical tests that are done in physicians' offices, clinics, and small hospitals who may not have access to the types of service available to the pathologists. To subscribe to the service, merely drop a line to Clinical Chemistry Control program, State Laboratory of Hygiene, Madison, Wisconsin 53706, stating where you wish the specimens sent.

—A. S. EVANS, M. D., Director, State Laboratory of Hygiene.

Recommendations of the Poliomyelitis Advisory Committee to the Wisconsin State Board of Health on the Use of Poliomyelitis Vaccines

The Poliomyelitis Advisory Committee to the State Board of Health, met on December 9, 1963, to discuss recommendations on the use of poliomyelitis vaccines after reviewing the recent reports on large-scale vaccination clinics in metropolitan and other areas in the USA. Based on evidence presented on the safety of the oral vaccines, participation in clinics and effectiveness of different dosage schedules, the following was recommended:

1. The school age and preschool children are the most frequent spreaders of the poliomyelitis viruses. Oral poliomyelitis vaccines can eliminate the carrier-state in our population. The primary target of immunization in poliomyelitis programs, in private practice as well as in public clinics, should be this age group. Special effort is needed to vaccinate the high school age population because experience indicates that a great number of these children did not receive protection.
2. To achieve the continuation of low poliomyelitis incidence, the newborn infants should be protected.
3. Accumulated evidence indicates that the hazards, previously believed to be associated with the use of oral vaccines, are as low or lower than with other commonly used vaccines.

   The Committee, therefore, rescinds its previous recommendation concerning the use of Salk vaccine prior to Type III feeding, and now recommends the unrestricted use of all three types of vaccine.
4. The following dosage schedules appear to be equally effective:
   a. Administration of single vaccine strains, with an interval of 4–6 weeks after each feeding of Type I and III vaccine, and an interval of at least 8 weeks after use of Type II vaccine.
   b. Feeding of trivalent vaccine, to be followed by a second dose 4–6 weeks later.
   c. One feeding of Type I vaccine, followed in 4–6 weeks, by administration of a mixture of Type II and Type III vaccines.
5. Signs and symptoms indicating central nervous system infection, occurring within 30 days after oral vaccine administration, should be followed by appropriate laboratory and clinical studies. A stool specimen and a blood specimen should be taken at the onset of any suggestive complication; a second blood specimen should be taken 3 weeks after the onset of such complications.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 151.15, Wisconsin Statutes, 1961.

For Improved Care of the OB Patient

The Wisconsin Maternal Mortality Study Committee would like to re-emphasize its position on 3 subjects.

1. OXYTOCICS: State Board of Health Rule H–26.063

"Nurses and non-medical personnel shall not administer oxytocics to ante-partum patients unless a physician is present." The implication of this rule is that the physician or his qualified medical representative must be available in the hospital when these drugs are administered, so that any medical emergency due to the drug action can be properly handled.

It should also be kept in mind that tocosamine is an oxytocic and comes under this rule.

The Maternal Mortality Committee further recommends that the method of choice for utilizing ante-partum oxytocics are by the dilute intravenous method. Intramuscular administrations is highly hazardous.

REFERENCE: *Wisconsin Medical Journal,* Vol. 62, pp. 476–477, November 1963.

2. TRILENE:

Trilene is an analgesic agent which is to be used in an approved inhaler and should be self-administered by the patient. It is not a safe agent for induction of anesthetic or for anesthesia itself and should never be administered by a nurse.

REFERENCE: *Wisconsin Medical Journal,* Vol. 62, p. 203, April 1963.

3. VAGINAL EXAMINATIONS ON PATIENTS IN LABOR BY NURSES:

Routine vaginal examinations by nurses on patients in labor is not recommended by this committee. It is the opinion that the hazards of infection far outweigh the advantages of this procedure over rectal examination in the following of patients who are in active labor. An obvious exception this would be a situation in which the physician directs the nurse to perform such an examination *with him.* This latter instance would be a good method of training nurses.—Prepared by J. R. EVRARD, M. D., Milwaukee, for Maternal Mortality Study Committee, by request, January 1964.

TAX GUIDE AVAILABLE

The Wisconsin Taxpayers Alliance has announced that the 1964 edition of TAXES, its annually published tax guide, is now available. TAXES provides easy-to-follow instructions on how to fill out both state and federal income tax returns. TAXES also includes information on all state and federal taxes levied in Wisconsin. The new tax changes made by congress and the Wisconsin legislature are incorporated in the 1964 edition.

Orders should be sent to the Wisconsin Taxpayers Alliance, Madison, Wisconsin 53703. The cost is 50 cents a copy.

FEDERAL DEDUCTIBILITY OF CERTAIN HEALTH AND ACCIDENT INSURANCE

Under a recent decision *total premiums* paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, in addition to surgical-medical or hospital benefits, are deductible medical expenses for *federal* income tax purposes. Such ruling does not, of course, change the limitation permitting the deductibility only of the excess of medical expenses over 3% of adjusted gross income up to the applicable maximum.

Previously the most that could be deducted on a policy which combined surgical-medical and hospital benefits with time loss or similar coverage was that portion of the total premium which represented an allocation of the surgical-medical or hospital benefits. In the case of the Provident plan carried by members of the State Medical Society, this was $17.00, only a minor part of the total average premium paid by member physicians.

Under the recent decision *total premiums* are deductible even though only *part* of each premium is attributable to surgical-medical or hospitalization benefits.

MEDICOLEGAL INFORMATION

AVAILABLE

Individual physicians or county medical societies may wish to make use of several informational materials and speakers on topics relating to medical-legal problems of physicians.

FILMS

The following films are available upon request to the State Medical Society of Wisconsin. Please allow at least two weeks advance notice if possible. These films were produced by Wm. S. Merrill Co. under direction of the American Medical Association, American Bar Association and American Hospital Association.

"Medical Witness"—Dramatically illustrates use of medical witness in court, providing do's and don'ts for effective testimony. Black and white, sound, 30 minutes.

"Doctor Defendant"—Suggests how the physician can prevent professional liability suits; shows county medical society grievance committee in action. Black and white, sound, 30 minutes.

"Man Who Didn't Walk"—Legal and medical aspects of personal injury case. Shows lawyers for plaintiff and defendant as they establish evidence from physicians, pretrial conference, and summation to jury. Black and white, sound, 30 minutes.

"A Matter of Fact"—Discusses the need for an adequate medical examiners' system versus the presently common coroners' system. Black and white, sound, 30 minutes.

"No Margin for Error"—Portrays certain aspects of physician-hospital activity bearing upon professional liability. Black and white, sound, 30 minutes.

"Silent Witness"—Deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court. Black and white, sound, 30 minutes.

SPEAKERS

County medical societies interested in obtaining speakers on medicolegal subjects may contact the State Medical Society, Box 1109, Madison 1, Wisconsin (phone ALpine 6-3101), or the State Bar Association of Wisconsin, 402 West Wilson Street, Madison, Wisconsin (phone ALpine 7-3838).

LITERATURE

Copies of the following materials are available upon request to the State Medical Society of Wisconsin:

* Interprofessional Code
* Medicolegal Forms With Legal Analysis
* Your Professional Liability (131 Questions and Answers)
* Professional Liability and the Physician
* Medical Legal Problems in Blood Transfusions

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1964, you must pay the final installment of the estimated federal and Wisconsin tax on your 1963 income. This may necessitate an amended declaration by that date if you find that you underestimated 1963 income. A final income tax return for 1963, filed before January 31, 1964, will be treated as the equivalent of an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1963 on Forms W–3 (Federal) and WT–7 (Wisconsin).
   (2) Furnish a statement to employees on Forms W–2 (Federal) and WT–9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1963.
   (3) File fourth quarterly return for 1963 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1963.
   (4) Pay income and social security taxes withheld on 1963 wages of employees if:
      (a) More than $100 was withheld in December, 1963, and not paid to government depositary earlier in January, 1964; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1963.

3. Miscellaneous:
   (1) If the total of federal income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on federal Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1964, for the respective preceding calendar quarters.
   (3) If federal income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to government depositary by the fifteenth of the following month. The amount of such withheld federal taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
   (4) Quarterly payments of Wisconsin income tax withheld must be made by the 20th day following the close of the calendar quarter unless the Wisconsin Department of Taxation requires you to report and pay on a different basis.

4. File your Wisconsin and federal partnership and personal income tax returns as early in 1964 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.

5. Estimates of Income; Quarterly Adjustments; Penalties.

The first quarterly estimate of your 1964 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax due, by April 15, 1964. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1964. As to the final payment or amendment of declaration due in January, 1965, follow the alternative procedure described in Section 1 above.

Excluding cases of willful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1964 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

ANNUAL REGISTRATION IN WISCONSIN

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, 1414 South Park Street, Madison, Wisconsin, 53715, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners and should be accompanied by the registration fee shown on that form.

ANNUAL NARCOTICS REGISTRATION

1. Register with the Bureau of Internal Revenue, Milwaukee, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1964. You are subject to penalties for overlooking either the registration or the tax.

CHANGE OF RESIDENCE

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

REMEMBER TO:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 2, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Section 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.

e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there is no physician in attendance.
h. When a physician refuses to sign the death certificate.

FEDERAL AND WISCONSIN UNEMPLOYMENT COMPENSATION LIABILITY

See in this connection the text of the box on page 50 of this issue.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1961.

NARCOTICS

Drugs Subject to Federal Laws

Treasury Department Bureau of Narcotics Circular No. 262 dated July 25, 1962, lists drugs subject to Federal narcotic laws. The circular was printed in full in the January 1963 issue of the *Wisconsin Medical Journal.*

Annual Registration

You must register with and pay the tax to the Bureau of Internal Revenue, Milwaukee, *before* July 1 to avoid penalties.

Change of Residence

Do not fail to notify the District Director of Internal Revenue, Milwaukee, of any change in address. Failure to notify him will make you subject to penalties.

In Case of Death

The Acting District Supervisor for this area wrote from Chicago on August 27, 1963, that the following conforms with current Federal Regulations.

> "The deceased physician's Special Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused order forms should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin. The narcotic drugs may be disposed of by shipment, charges prepaid (shipments by mail shall not be made) to the District Supervisor, Federal Bureau of Narcotics, 817 New Post Office Building, Chicago, Illinois 60607, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs."

Preprinted Prescription Blanks

The Narcotics Bureau of the Internal Revenue Service reports that neither Federal law nor administrative regulation prohibits the printing of the physician's narcotic registration number on prescription blanks. However, the Narcotics Bureau prefers that physicians have their prescription blanks printed without including the narcotic registry number. According to the Bureau, if the physician follows the practice of writing in his registry number at the time narcotic prescriptions are issued, it will facilitate the easier detection of forged prescriptions.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past-president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As last amended by the 1963 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

No person shall hold more than one of such offices concurrently.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and

shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Public Relations and Communications
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of five *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Commission on Public Relations and Communications shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Public Relations and Communications shall study, make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven members, and the president, the president-elect and secretary. The commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each number appointed for a term of three years.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine. shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed

to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1961.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

"March of Medicine" is in its nineteenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature H. Kent Tenney, M.D., discussing various health problems with a lay person who is called "Your Medical Reporter." At present 51 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	11:15 a.m.
*WLBL	Auburndale	Wednesday	9:15 a.m.
WWIS	Black River Falls	Saturday	10:45 a.m.
*WHSA	Brule	Wednesday	9:15 a.m.
*WHKW	Chilton	Wednesday	9:15 a.m.
WAXX	Chippewa Falls	Saturday	8:30 a.m.
*WHWC	Colfax	Wednesday	9:15 a.m.
*WHAD	Delafield	Wednesday	9:15 a.m.
WBIZ	Eau Claire	Sunday	6:45 p.m.
WERL	Eagle River	Saturday	9:45 a.m.
KFIZ	Fond du Lac	Sunday	9:45 a.m.
WJPG	Green Bay	Saturday	8:45 a.m.
WHSM	Hayward	Saturday	9:45 a.m.
*WHHI	Highland	Wednesday	9:15 a.m.
*WHLA	Holmen	Friday	10:30 a.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:10 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Wednesday	9:15 a.m.
*WHA-AM	Madison	Wednesday	9:00 a.m.
*WHA-FM	Madison	Wednesday	9:00 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Sunday	10:30 p.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	9:45 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WMNE	Menomonie	Thursday	10:45 a.m.
WNAM	Neenah	Sunday	7:05 p.m.
WCCN	Neillsville	Saturday	9:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	11:15 a.m.
WPDR	Portage	Thursday	10:45 a.m.
WIBU	Poynette	Thursday	2:35 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WCWC	Ripon	Saturday	10:45 a.m.
WTCH	Shawano	Saturday	6:15 p.m.
WDOR	Sturgeon Bay	Tuesday	9:05 a.m.
WQMN	Superior	Saturday	12:00 p.m.
WTMB	Tomah	Wednesday	2:00 p.m.
WTRW	Two Rivers	Wednesday	11:00 a.m.
WISV	Viroqua	Saturday	8:45 a.m.
WTTN	Watertown	Friday	11:30 a.m.
*WHRM	Wausau	Friday	10:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

* Radio stations in the state network.

Life is short...

Art is long...

Experience is difficult

One of the first recorded admonitions of Hippocrates to fellow physicians concerning medicine are the Latin words contained in the emblem symbolic of this Foundation. These words as they appear in their literal translation as above are as true today as they were when first spoken.

It is indeed obvious that the need for more and better medicine is becoming more and more paramount as we come to understand the human processes to ever greater degrees.

Together with this growth of knowledge must come increased public understanding of it, so that the people it is to benefit will take advantage of its availability.

By far the best means of accomplishing this is through the efforts of an educational and scientific foundation specifically formed for these purposes.

The Charitable, Educational and Scientific Foundation

of the

State Medical Society of Wisconsin

THE CHARACTER of the medical profession shapes not only its own destiny but has profound influence on the health and well-being of all the people. This character finds its roots in the age-old belief that individual freedom and well-being hinge on people helping themselves and one another. For 123 years, the State Medical Society of Wisconsin has reflected this spirit in its activities and in its services to the public and to member physicians.

The Charitable, Educational and Scientific Foundation of the Society was created in 1954 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health.

The Foundation administers such gifts in accordance with the wishes of the givers. Gifts or grants made to the Foundation are tax deductible by donors, whether they be individuals or corporations.

The following pages explain a few of the many and varied activities of the Foundation.

MEDICAL STUDENT LOAN FUND

The financial needs of the modern medical student are substantial. It is estimated that nearly 50% of the students at Marquette University or the University of Wisconsin medical schools are—at some point in their schooling—so financially embarrassed as to jeopardize their continued education.

To assist those who have already started their medical careers, and to encourage those still in pre-college work, the Society, in 1951, created a Student Loan Fund. With the establishment of the Foundation, this activity was absorbed and expanded.

Since 1951, more than $100,000 has been loaned to over 100 medical students from all areas of Wisconsin, and a few from out-of-state and foreign countries.

During 1963, the Foundation granted loans totaling over $10,000 to 14 medical students enrolled at Marquette University and the University of Wisconsin medical schools. Several applications are pending for which no funds are available. It has been estimated that the Loan Fund will not fully achieve its purpose until $250,000 or more is available for needy and deserving students.

Applicants for loans must be registered students in an approved medical school. Current limitations on available funds require that applicants be residents of Wisconsin attending Marquette or the University of Wisconsin medical schools.

Loans are granted generally in amounts not in excess of $1,000 per year for a total of three years. No interest is assessed until the student is licensed and has completed military-medical service. All loans are secured by a $2,000 life insurance policy or the amount of the loan, whichever is greater. A student receiving a loan places himself under no obligation to practice in a predetermined location.

The Student Loan Fund of the Foundation is still far short of its ultimate goal. Through it, physicians and others can make a singular contribution to those of their brothers for whom finances constitute a special hazard in the pursuit of professional knowledge.

SCIENTIFIC MEDICINE

Medicine is an ever-changing and increasingly complex science. The physician is faced with a never-ending challenge to maintain his art and skills at a level that keeps pace with scientific progress.

During the past year (1963), a total of 910 physicians and 136 hospital personnel attended postgraduate programs sponsored by the Foundation. These included conferences on obstetrical deaths, a special program honoring the memory of Wilson Cunningham, M.D., Platteville, and a variety of special teaching programs for generalists and for county medical societies.

The significance of these cannot be understated. Only through continued improvement and expansion of knowledge and skill can the physician bring the latest in medical diagnosis, treatment, and cure to the public.

A Speakers Service, available to county medical societies, is also available through the Foundation. This program is regarded as a vital means of bringing the latest in scientific knowledge from Wisconsin's two medical centers, as well as from outstanding physicians around the state.

This service is particularly helpful to the smaller medical societies and those more remote geographically. Through the Foundation they are encouraged to utilize the Speakers Service because, even though listeners may be few in number, the overall impact on the health of the people in Wisconsin will be great.

Annually, the Foundation supports from three to ten circuit teaching programs in various parts of the state. A wide variety of subjects is discussed at each of these conferences. They are particularly beneficial to the busy generalist in the small community.

The Foundation also annually supports and participates in research in many fields in cooperation with various other agencies, such as The American Medical Association.

The field of scientific education is as wide and high as the practice of medicine itself. As newer techniques in diagnosis and treatment develop, it is necessary that these be transmitted to practicing physicians and those allied with them.

The Foundation offers an opportunity for individuals and organizations to contribute to this field of special education and thus directly affect the level of health care of the people of Wisconsin.

MUSEUM OF MEDICAL PROGRESS

The history of medicine is told in a historic setting at the Museum of Medical Progress at Prairie du Chien. The Museum is housed in the restored military hospital of old Fort Crawford, which played a prominent part in the history of the Midwest.

It was at Fort Crawford's hospital that Dr. William Beaumont made many of his famous studies of gastric juice and the physiology of the stomach. The story of this doctor's world famous studies in a remote frontier hospital is one of the exhibits on display. A recreation of the Doctor's office is also exhibited; it contains some of his personal effects and other equipment used by physicians in his time.

The basic display area of the Museum is divided into four sections:

1. Portrayal of the development of early medicine from Indian remedies through the settling of the Midwest.

2. The doctor on horseback and the horse and buggy doctor.
3. Exhibits taking the viewer from the turn of the century to the present.
4. A special area devoted to changing exhibits in the field of general health education. A portion of it is devoted to outstanding current projects of high school students which the Museum makes an effort to encourage and display.

The Museum of Medical Progress is operated as one of the five major historic sites in the State by the State Historical Society of Wisconsin under guidance from the Foundation's Permanent Commission for the Museum of Medical Progress. Development in the quality and variety of exhibits has been substantial. This has been made possible through the interest of countless individuals in the state who have furnished medical memorabilia for use in displays, and contributed countless hours of time in guiding the scientific aspects of the presentation.

RESEARCH ACTIVITY

As previously mentioned, the Foundation supports and participates in research with other agencies through funds made available by gifts or grants. In the past these activities have been regulated by the specifications and desires of the giver. They have included such efforts as research on loss of hearing, medical insurance needs of the aged, and the general costs of health care.

It is the sincere hope that with additional funds these research activities will be expanded.

Any project worthy of pursuing will be carefully considered and the possibility of doing a justifiable job with the proposed funds will be determined, before being accepted.

MICROSCOPE LOAN

The Foundation has acquired through contributions several microscopes which have been used by physicians. These are made available to medical students for use in their studies. More such instruments are sorely needed.

MEDICAL STAMPS

In 1958 the Foundation undertook the collection of postage stamps which commemorate occasions of public health achievements or memorialize scientists and physicians who have contributed to the progress of medicine.

Now numbering more than 3,000 issues, the collection is being used to illustrate talks on health careers, the progress of medicine in public health, and other public showings.

HISTORICAL MARKERS

Medical historical markers are being erected in Wisconsin to show the significance of medical science as it develops in Wisconsin and the nation.

The Foundaton is cooperating with the Section on Medical History in recording information and developing a program whereby such historical markers will serve an important function in public education.

POLICY AND ADMINISTRATION

The Foundation is a non-stock corporation under Wisconsin Statutes. It is directed by a Board of Trustees composed of an elected member from each component medical society, the Councilors and Officers of the State Medical Society and up to ten non-medical Trustees.

Terms of the county society representatives are for three years and are staggered so that approximately one-third of the members are elected each year. This helps to insure stability to the board.

Although the membership of the Board of Trustees numbers 90, the officers and executive committee constitute a small enough number to work efficiently in governing.

The Councilors and Officers of the State Medical Society constitute the Executive Committee of the Board. An annual meeting of the Board is held at the same time as the Annual Meeting of the State Medical Society. Officers are elected at that time.

With a continuing liaison at the county medical society level throughout Wisconsin, and with the Foundation under direct management of the governing body of the State Medical Society itself, the traditions and continuity of organized medicine in Wisconsin can be assured. Furthermore, such an arrangement assures that projects and activities undertaken by the Foundation will represent or reflect a personal and realistic approach to the many problems of medicine and public health.

OPPORTUNITIES FOR GIVING

Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

Gifts may be unrestricted permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor.

What will happen in the future? The obligations and opportunity are waiting.

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of the State Medical Society of Wisconsin

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Huston, H. C.
Ihle, C. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Owen, G. E.
Paulson, W. O.
Reed, R. D.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Sperry, V. A.
Strand, R. C.
Thimke, H. E.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.
Zlegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey, D. W.
Dailey, P. J.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Rawlins, J. A.
Rogers, R. J.
Sablay, Nonito
Sorenson, E. D.

Ellsworth:
Jonas, E. R.

Elm Grove:
Clark, R. A.
Dall, G. A.
Damiano, N. F.
Denio, M. J., Jr.
Erwin, C. P.
Erwin, C. R.
Grade, J. O.
Hanson, E. R.
Mateicka, W. E.
McCormick, G. E.
Millington, P. E.
Myers, S. C.
Redlin, R. R.
Settimi, A. L.
Wisniewski, J. H.
Zurheide, H. J.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Bissegger, Arnold
Borsack, K. K.
Cerny, F. J.
Charles, J. E.
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Hitselberger, J. F.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Koll, J. H.
Leonard, C. W.
Llewen, B. E.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meisinger, G. F.
Myers, W. E.
Nemeth, Charles
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sigalove, W. H.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Thomas, H. R., Jr.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.

Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Sargent, C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Russell, J. C. H.
Vognar, S. F.
Voytek, J. J.

Fox Lake:
Duxbury, W. J.
Snook, W. H.

Fox Point:
Martin, D. H.
Peters, L. M.
Sibberman, Jack
Thompson, L. H.

Frederic:
Andrews, W. C.
Fischer, W. A.
Moore, R. M.

Fremont:
Gloss, A. J.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Lastrilla, R. S.

Gillett:
Klutzow, F. W.

Glendale:
Brazy, R. R.
Thompson, B. W.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Grafton:
Pelant, K. F.
Seidl, J. A.

Grantsburg:
Cutshall, R. A.
Hartzell, R. L.
Stageman, John F.

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Angus, D. C.
Austin, S. D.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Bramschreiber, J. L.
Brusky, A. H.
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Burdon, T. S.
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Christensen, P. D.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
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Denys, G. F.
Dettmann, J. E.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gehring, J. V.
Goelz, J. R.
Grace, J. B.
Griggs, S. L.
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Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Halloin, J. E.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Hoops, H. J. Jr.
Icks, K. R.
Jensen, R. E.
Johnston, R. E.
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Killeen, E. R.
Killins, J. A.
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Kulkoski, Bernard
LaFlare, J. P.
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Levitas, I. E.
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Myers, R. L.
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Nicolaus, W. H.
Ottum, J. A.
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Randall, J. H.
Robb, J. J.
Rose, R. J.
Sandmire, H. F.
Schibly, W. J.
Schmidt, R. T.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Slightam, P. E.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoll, W. M.
Sullivan, Donel
Theiler, G. J., Jr.
Theisen, J. K.
Thompson, L. L.
Troup, R. H.
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Urban, Frank
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Wunsch, C. A.
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Grosshandler, S. L.
Kuglitsch, E. F.

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Kozina, T. J.

Green Lake:
Leininger, A. T.

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Litzen, F. L.

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Damiano, N. F.
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Pierce, D. F.
Rath, E. K.
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Sortor, R. F.
Wolf, R. C.

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Arrambide, George
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Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

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Callaghan, D. H.
Krueger, E. R.
Sahs, M. H.
Wyant, M. E.

Haywood:
Stang, H. M.

Hazel Green:
Klein, G. J.
Farbstein, M. E.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
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Karsten, J. H.
Schulz, N. H.
Schutz, W. J.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Timp, L. F.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

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Meyer, C. F.

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Wood, C. F.

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Albrecht, J. E.

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Baker, C. S.
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Baylon, V. A.
Betlach, Dorothy M.
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Chicks, C. O.
Clark, W. T.
Cooper, T. H.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Holland, R. A.
Karzel, R. P.
Koch, V. W.
Lakritz, Amrum
Levin, Harland
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McNichols, E. F.
McSweeny, A. J.
Nash, C. B.
Neeno, Katsumi
Nolta, R. T.
Nuzum, T. O.
O'Brien, J. N.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Peters, E. E.
Peterson, Geo. H.
Purdy, M. F.
Rau, Esther L.
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Russo, F. R.
Sabado, E. F.
Sargeant, T. S.
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Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Thomas, G. L.
Tordoff, J. J.
Vogel, T. L.

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Busse, A. A.
Quandt, C. E.
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Siedenburg, Richard

Johnson Creek:
Wendt, F. A.

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Haessly, F. G.
Heath, H. J.

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Boyd, G. L.
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Jeffrey, J. S.
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Skibba, J. P.

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Armstrong, G. F.
Ashley, R. W.
Balciunas, V.
Barnes, E. H., III
Bilak, R.
Binnie, Helen A.
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Bode, M. J.
Bonell, B. T.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Creighton, L. H.
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Currie, R. E.
Davin, C. C.

Davis, D. W.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Ferwerda, J. R.
Garren, J. T.
Gerol, A. Yale
Gerstle, Walter J.
Goldstein, D. N.
Graves, J. P.
Halfon, Nesim
Hatfield, M. E.
Hauschild, W. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, C. E., Jr.
Pechous, Lillian
Peterson, C. E.
Powell, R. A.
Rafferty, H. P.
Randall, A. J.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rufflo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Sipos, Stephen
Swift, W. J., Jr.
Turner, Lewis, III
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Wiarda, R. J.
Williams, F. C., Jr.
Wood, Fredrick, Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
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Lanier, Patricia A.
Nesemann, R. M.
Wits, E. W.

Kiel:
Nauth, D. F.
Schultz, W. F.
Theiler, A. C.
Twohig, G. J.

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Gage, Ralph S.

King:
McGinnis, H. J.

Kohler:
Gascoigne, C. C.
Rowe, D. M.

La Crosse:
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Alvarez, U.
Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Brailey, A. G., Jr.
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.
Copps, S. A.
Corser, D. H.
Dalton, R. M.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
Egan, J. F.
Ellenz, G. B.
Ernst, F. W.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, F. J.
Gallagher, W. B.
Gatterdam, P. C.
Getz, Kaare
Gilbert, R. L.
Gorenstein, L. M.
Guernsey, Gretchen
Gundersen, A. H.
Gundersen, A. L.
Gundersen, G. A.
Gundersen, Gunnar
Gundersen, S. B., Jr.
Gundersen, T. E.
Hayden, J. W.
Helliesen, P. J.
Hickey, A. W.
Higgins, C. K.
Himmelsbach, W. A.
Hulick, P. V.
Jones, W. J.
Joseph, L. G.
Kalfayan, Bernard
La Brec, H. C.
Lefsrud, J. B.
Leiby, R. W., Jr.
MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
Murphy, G. B., Jr.
Murphy, J. T.
O'Meara, M. T.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Reinert, John E.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Simones, J. J.
Sivertson, S. E.
Skemp, F. C.
Skemp, G. E.
Skemp, J. J.
Skemp, J. T.
Slungaard, Rolv
Thompkins, D. G.
Uhrich, G. I.
Watunya, M. J.
Whiteway, R. E.
Wolf, F. H.
Yutuc, W. R.

Ladysmith:
Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

La Farge:
Lee, Connie

Lake Geneva:
Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:
Eck, G. E.
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.
Turcott, R. A.

Lancaster:
Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.

Land O' Lakes
Eickhoff, E. C.

Laona:
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose, J. F.

Little Chute:
Buchanan, K. E.
Van Lieshout, F. X.

Lodi:
Groves, R. J.
Irwin, W. G.

Loyal:
Gungor, B. O.
Hable, A. P.

Luxemburg:
Majeski, H. E.

Madison:
Aageson, C. W.
Ainslie, R. B.
Albright, E. C.
Allen, A. S.
Allen, J. C.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Angevine, D. M.
Ansfield, F. J
Ashman, H. C.
Barks, M. F.
Bamforth, Betty J.
Barber, J. L.
Barbour, J. H.
Barreto, R. S. A.
Bartlett, W. H.
Bauman, B. J.
Becker, R. M.
Beilman, R. L.
Belknap, E. L., Jr.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berg, Mary C.
Berger, J. V., Jr.
Bernard, F. D.
Bessire, M. C.
Blair, A. J.
Blancke, F. W.
Bloodworth, J. M. B., Jr.
Blum, F. G., Jr.
Bogle, W. C.
Bohlman, D. C.
Boldon, E. I., Jr.
Borenz, H. F.
Botham, R. J.
Brandabur, J. J.
Brew, Barbara A.
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Britton, D. M.
Brodhead, Wm. T.
Brown, J. G.
Bruno, D. S.
Bryan, G. T.
Burke, C. F.
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Burke, Myra E.
Burnett, G. H.
Burns, E. M.
Burns, R. E.
Buxbaum, R. C.
Calvert, Charlotte
Campbell, R. E.
Cant, W. F.
Carter, H. M.
Chase, S. L.
Cherry, J. D.
Clatanoff, D. V.
Clausen, N. M.
Clinton, G. L.
Collins, R. F.
Connors, D. M.
Cooksey, R. T.
Cookson, D. U.
Cooper, G. A.
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Cowle, A. E.
Crennell, E. H.
Crocker, L. G.
Crowley, W. P., Jr.
Crummy, A. B., Jr.
Crumpton, C. W.
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Curreri, A. R.
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Davenport, Gordon, Jr.
Davidson, P. L.
Davis, F. A.
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Dickie, Helen A.
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Dimond, W. B.
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Dollard, J. E.
Domine, A. Z.
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Dudiak, Stephen
Duehr, P. A.
Dunn, W. S.
Eichman, P. L.
Ellis, J. C., Jr.
Erickson, M. T.
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Evans, A. S.
Everett, H. C.
Ewell, G. H.
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Felton, O. L.
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Forster, F. M.
Foseid, Oscar F.
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Gale, J. W.
Gallo, G. L.
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Garnett, G. M.
Geocaris, Konstantin
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Hamel, Merle O.
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Hank, G. C.
Harper, C. S.
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Harris, R. C.
Hartridge, T. L.
Hawk, E. A.
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Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hinke, D. H.
Hobbins, W. B.
Hoff, A. D.
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Hopkins, C. E.
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Howard, D. R.
Hummer, F. L.
Hunter, Amy Louise
Hurst, D. W.
Hutson, C. F.
Iams, A. M.
Inhorn, S. L.
Jackson, A. S.
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Jackson, R. H., Jr.
Jaeschke, W. H.
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Johnson, J. R.
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Jorris, E. H.

Juhl, J. H.
Juster, E. M.
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Kanner, A. V.
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Kay, H. M.
Keepman, Jay P.
Kemp, T. S.
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Knight, C. C.
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Korbitz, R. F.
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Breier, H. P.

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Mount Horeb:
Morrison, M. T.

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Hicks, E. V.
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Weber, J. W.

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Park Falls:
Enzinger, Josef
Eyvindsson, E. T.
Leahy, J. D.
Murphy, J. L.

Peebles:
Menne, F. R.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine
Blahnik, C. L.

Pewaukee:
Kelly, J. P.

Phelps:
Wolcott, R. R.

Phillips:
Niebauer, W. E.
Rens, J. L.

Plain:
Fowler, Paul H.
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Doeringsfeld, H. L.
Moffett, J. L.
Nuland, S. J.
Steidinger, C. L.
Stuessy, M. F.

Plum City:
Docter, C. W.

Plymouth:
Alvarez, R. J.
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Steffan, L. J.
Weisse, H. A.

Portage:
Aszman, P. E.
Cooney, R. T.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.
Villavicencio, C.

Port Washington:
Barr, A. H.
Corcoran, W. A., Jr.
Henkle, R. F.
Kauth, C. P.
Muehlhaus, F. R.
Savage, G. F.
Wallestad, P. W.
Walsh, John F.

Pound:
Peikey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Satter, O. E.
Shapiro, H. L.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Zauft, G. W.

Prairie Farm:
Roemhild, F. N.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Alexander, A. C.
Bacon, G. A.
Barina, H. J.
Bein, Robert
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brewer, G. W.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Burke, Donald
Case, Q. C.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Cushman, S. M., Jr.
DeGroot, H. E.
Docter, J. C.
Dorman, T. W.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Fogle, R. J.
Fralich, J. C.
Gradetto, P. A.
Gehring, C. A.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hammes, J. R.
Harris, W. C.
Hemmingsen, T. C.
Henken, J. F.
Henken, W. F.
Herrmann, A. A.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Holman, J. H.

Jacobsen, A. J.
Jamieson, J. G.
Johnson, P. S.
Jones, Beatrice O.
Jones, L. E.
Kaarakka, O. F.
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Lifschutz, L. M.
Lindner, A. M.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Madden, W. J.
Martinez, M. E.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, J. R.
Miller, P. L.
Miller, V. M.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Petersen, J. J. G.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Shack, J. B.
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
Sumida, Shigeo
Tomkiewicz, R. E.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H.
Wright, R. S.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Simeon, R. G.
Stadel, E. V.
Tibbitts, J. A.

Reedsville:
Leering, Hendrik

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Haug, Thomas M.
Johnson, A. G.
Litton, E. W.
Litton, M. A.
Mescher, T. J.
Nevin, Ismail Nik
Osborne, R. R.
Pratt, G. F.
Rosemeyer, O. G.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
Engels, E. P.
Filiatrault, L. J.
Gillespie, M. E.
Hoyer, J. K.
Kristensen, L. A.
Lameka, Peter
Lind, J. A.
Maser, J. F.
McKenzie, J. R., Jr.
Rydell, O. E.
Rydell, W. B.

Richland Center:
Edwards, R. W.
Edwards, W. C.
Glise, Roy C.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.
Tydrich, J. J.

Rio:
Langmack, W. A.
Maas, W. C.

Ripon:
Bachus, A. C.
Dittmer, O. A.
Flaherty, T. T.
Johnson, J. M.
Lofdahl, S., Jr.
Pelton, R. S.
Schuler, W. H.

River Falls:
Dohnalek, D. W.
Grassl, F. O.
Gutzler, P. H.
Hammer, R. M.
Haskins, P. S.
Orlow, W. O.

Rosholt:
Benn, V. A.

St. Croix Falls:
Ericksen, D. M.
Fink, D. W.
Nelson, L. K.
Olson, L. L.
Riegel, F. B.
Riegel, J. A.
Thompson, R. C.
Wegner, M. E.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, E. T. F.
Walsh, T. W.

Schofield:
Olson, M. H.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Cantwell, A. A.
Cantwell, R. C.
Coan, W. A.
Harned, R. K.
Jeffries, Donald A.
Laufenburg, H. F.
Logemann, R. L.
Peterson, L. W.
Schulz, D. W.
Sebesta, A. J.

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Batzner, D. J.
Bock, A. B. C.
Braun, N. P.
Bringe, J. W.
Cinelis, Ann A.
Dick, H. J.
Eckardt, B. F.
Graf, C. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Huibregtse, W. G.
Jaeck, J. L.
Jochimsen, E. H.
Keller, R. A.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Michael, J. D.
Moir, Jane M.
Moir, W. W.
Mooney, F. L.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Pointer, R. W.
Quinn, G. A.
Reinemann, J. M.
Schlichting, J. E.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Weygandt, J. L.

Shell Lake:
Flogstad, Duane
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shorewood:
Davis, D. P.
Simonsen, H. W.
Vlazny, F. J.

Shullsburg:
Gratiot, Mary P.
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
McFadden, Wayne
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Roob, D. M.
Spencer, G. N.
Theisen, C. E.
Turgai, Valerio
Zahl, W. H.

South Wayne:
Creasy, L. E.

Sparta:
Albrecht, P. G.
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Green:
Kempthorne, G. C.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.
Sallis, D. A.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Dunn, A. G.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Kelly, J. R.
Kohn, A. M.
Litzow, J. A.
Milano, Angelo
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Sanders, R. H.
Schierl, A. G.
Sciarrone, F.
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stone Lake:
Marlewski, C. R.

Stoughton:
Hermundstad, O. A.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, P. J.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Dorchester, D. E.
Grota, H. D.
Hobson, W. S.
Murphy, J. T.
Sheets, W. G.
Wagener, N. R.

Sun Prairie:
Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Raymond, L. A.
Russell, W. T.

Superior:
Anderson, R. T.
Carpenter, E. E.
Doyle, T. J.
Ekblad, V. E.

Finn, Milton
Foderick, J. W.
Fruehauf, R. P.
Giesen, Conrad W.
Johnson, F. G., Jr.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Sandgren, G. R.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.

Thiensville:
Albright, Howard
Elbe, T. D.
Herman, Murray
Levy, E. S.

Thorp:
Neis, F. P.

Three Lakes:
La Ham, J. T.

Tigerton:
Helse, L. F.

Tomah:
Bryan, A. W.
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.
Ryan, C. J.

Tomahawk:
Baker, R. G.
Bugarin, N. L.
Henderson, R. J.
Jarvis, D. F.
McCormick, W. C.

Turtle Lake:
Halberg, A. C.

Two Rivers:
Kaner, S. L.
Kozelka, A. W.
Kuljis, D. A.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Haedike, W. D.
McCracken, R. W.
Schulz, G. J.
Winter, B. V.

Valders:
Acheson, W. E.
James, R. L.

Verona:
Noll, D. J.
Pellett, J. R.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Starr, R. A.
Syty, Joseph
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O S.

Walworth:
Bruhn, I. J.
Coon, W. W.
Hansen, D. R.
Kroyer, T. J.

Washburn:
Guzzo, Harold
Telford, J. G.

Washington Island:
Rutledge, P. E.

Waterford:
Bardenwerper, H. W.
Dietz, R. J.

Waterloo:
Gagan, R. J.
Garman, J. S.
Kennedy, F. H.

Watertown:
Baldwin, R. C.
Becker, J. H.
Burzynski, E. E.
Hahn, A. C.
Miller, E. A.
Nowack, L. W.
Reed, W. H.
Schuh, E. P.

Waukesha:
Alston, J. A.
Bartos, J. A.
Bartos, R. E.
Bemman, K. C.
Bischel, J. R.
Bolger, James V.
Brown, W. E.
Burch, R. N.
Cafaro, A. F.
Campbell, P. E.
Campbell, W. B
Carroll, P. E.
Church, Ruth E.
Clothier, W. J. K.
Davies, E. B.
Davies, Gwilym
Desch, C. A.
Dugan, T. E.
Edmondson, C. C.
Edson, J. D.
Feulner, R. C.
Frantz, R. G.
Fruchtman, M. Z.
Gantz, H. A.
Gilbert, Francis
Guy, J. R.
Hillan, D. D.
Kaschat, R. L.
Kritter, A. E.
McCormick, G. L.
McDonell, T. H.
Merkow, William
Monk, R. S.
Motzel, A. J., Jr.
Nolan, J. L.
Peterson, J. A.
Promer, J. E.
Rasmussen, R. J.
Schmidt, C. W.
Schulz, E. G.
Settlage, H. A.
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A.
Weis, T. W.
Werra, B. J.
Werra, M. J.
Wood, C. A.
Zietlow, F. G.

Waunakee:
Marquis, W. R.

Waupaca:
Boudry, M. O.
Haman, K. L.
Salan, J. R.
Salan, Sam
Steiner, J. H.

Waupun:
Barajas, Rafael
Hebenstreit, A. J.
Hull, H. H.
Petters, W. J.
Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

Wausau:
Anderson, J. A.
Andrews, G. R.
Bachhuber, G. J.
Backer, G. L.
Balliet, C. M.
Bartholomew, R. D.
Becker, W. T.
Brick, E. B.
Brister, G. H.
Brodhead, R. H.
Burr, Thurl C., Jr.
Christensen, H. W.
Fechtner, H. H.
Flannery, J. V.
Flemming, E. E.
Foerster, J. M.
Freeman, D. J.
Freeman, J. M.
Gargas, B. L.
Grauer, C. G.
Hammes, G. R.
Hendrickson, A. O.
Hendrickson, W. O.
Hoessel, A. W.
Johnson, F. C.
Jones, M. L.
Juers, R. H.
Kass, R. M.
Kelley, O. R.
Kline, C. L.
Knutson, K. R.
Kordiyak, George
Kramer, J. D.
Larsen, R. B.
Locher, W. G.
Ludwig, E. P.
Mallery, O. T.
McCandless, E. E.
Miller, T. O.
Miller, W. C.
Mollnaro, A. J.
Norton, W. I.
Nowinski, D. M.
Peterson, T. H.
Prehn, F. C.
Rudy, W. B.
Schroth, G. J.
Shannon, R. C.
Shaw, W. R.
Smith, B. K.
Songe, R. A.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Struthers, J. L.
Thackeray, R. C.
Thorgersen, T. M.
Trumbo, J. K.
Uecker, R. L.
Williamson, L. M.
Wilson, O. M.
Yoran, C. M.

Wautoma:
Beck, A. A.
Darby, R. C.
Klasinski, C. A.
Slattery, F. G.

Wauwatosa:
Appleby, K. B.
Arneth, J. J.
Baker, W. V.
Beck, K. H.
Beffel, J. M.
Beltran, D. J.
Berglund, G. A.
Bookhamer, J. W.
Boyle, R. W.
Brault, R. G.
Brook, J. J.
Burgardt, G. F.
Calvy, D. W.
Curtis, William C.
Dettmann, N. F.
Dohearty, W. H.
Engstrom, W. W.
Feiersteln, W. E.
Fifrick, L. L.
Flanary, J. R.
Flanary, L. M.
Headlee, C. R.
Higley, R. A.
Jenk, L. F.
Josephson, Morton
Kebbekus, R. A.
Kehlnhofer, F. H.
Klopfer, W. P.
Kocovsky, E. C.
Kradwell, W. T.
Liefert, K. A.
Lorton, W. L.
Malloy, P. J.
Marck, Abraham
Martens, E. W.
McDermott, J. F.
McGrath, D. J.
Nordin, P. F.
O'Connell, James R.
Osgood, C. W.
Patterson, R. H.
Pendergast, T. J.
Pilliod, J. V.
Ricciardi, I. J.
Ruskin, B. A.
Russell, R. J.
Schmidt, E. J.
Schmidt, J. R.
Schulte, W. J.
Schwartz, W. R.
Selfert, K. A.
Stoehr, B. J.
Stuhler, J. D.
Teeter, R. R.
Turrell, E. S.
Twelmeyer, H. F.
Wells, R. K.
Winters, K. J.
Wood, D. L
Worm, G. J.

Webster:
Maas, D. A.

West Allis:
Bemis, E. L.
Bertolaet, E. E.
Collins, E. G.
Couch, J. R.
Couch, T. T.
Cramer, R. P.
Everts, E L.
Fieber, W. W.
Frederick, R. H.
Fulton, J. W.
Heinan, F. C.
Hermann, W. C.
Jochimsen, M. A.
Malensek, M. C.
Miner, D. L.
Nefches, M. S.
Rumhoff, Gordon
Smits, R. H.
Stamm, M. P.
Stern, C. S.
Stern, L. S.
Stern, R. S.
Toepfer, R. A.
Wilkinson, E. D.
Wilkinson, J. J.
Zenz, Carl
Zimmer, J. F.
Zimmer, J. J.

West Bend:
Bauer, K. T.
Baumgartner, J. F.
Bush, F. I.
Driessel, R. H.
Frankow, R. O.
Gibson, R. D.
Grundahl, A. T.
Hearn, R. F.
Nielsen, W. A.
Olsen, E. H., Jr.
Scheunemann, W. E.
Schulz, J. H.
Sorensen, R. F.
Struck, Eleanor C.

Westby:
Bland, P. T.
Otterson, W. N.

West De Pere:
Gutheil, D. A.
Lenz, R. B.

West Salem:
Gersch, G. P.
Goedecke, R. H.
Gundersen, S. B.
Lloyd, B. E.
Morris, D. L.
Swarthout, Edyth C.
Wakefield, G. F.

Westfield:
Demke, R. L.
Fredrick, H. Y.

Weyauwega:
Maasch, L. P.

Whitefish Bay:
Brady, J. J.
Farrell, H. J.
Gruender, J. E. M.

Whitehall:
Hanley, L. L.
MacCornack, R. L.
Simons, N. S.

Whitewater:
Ambrose, S. H.
Miller, R. H.

Wild Rose:
Hong, Roy
Kjentvet, R. A.
Wichmann, R. D.

Williams Bay:
Wiswell, C. Y.

Winnebago:
Bachhuber, H. M.
Belcher, C. H.
Bittle, K. A.
Bobowski, C. D.
Bujard, R. S.
Denzel, H. A.
Gruener, C. E.
Gursoy, Erdaly
Kubiak, Mary K.
Loftus, E. R.

Winneconne:
Effenhauser, M.
McDonald, D. H.

Wisconsin Dells:
Broderick, C. F.
Conley, H. L.
Gissal, F. W.
Houghton, J. H.

Wisconsin Rapids:
Arendt, C. J.
Arendt, N. W.
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Hulme, A. W.
Johnson, R. L.
Lucas, A. M.
Nelson, W. L.
Pomainville, H. G.
Pomainville, L. C.
Schaller, J. W.
Shapiro, David
Shields, G. G.

Withee:
Johnson, J. W.

Wittenberg:
Olson, M. H.

Wonewoc:
Baker, H. P.

Wood:
Cohen, A. M.
Dessel, B. H.
Dowling, J. J., Jr.
Gas Parri, P. G.
Henschel, E. O.
Kory, R. C.
Leitschuh, T. H.
Levin, J. J.
Mahaffey, C. H.
Milson, S. E.
Remus, C. J.
Ruetz, P. P.
Stengel, B. F.
Unger, J. D.
Zeps, A. A.

Woodruff:
Pfeiffer, O. W.
Hiatt, W. R.

Woodville:
Heiser, P. Arthur

Wrightstown:
Vande Loo, F. B.

Out-Of-State Members

Allen, L. L. ----------Philadelphia, Pennsylvania
Bailey, D. W. ----------Albuquerque, New Mexico
Balistreri, Frank ----------Hinsdale, Illinois
Banyai, A. L. ----------Chicago, Illinois
Barcome, D. F. ----------Houston, Texas
Baum, E. L. ----------Naples, Florida
Belshe, J. C. ----------Minneapolis, Minnesota
Belza, Janusz ----------Palo Alto, California
Berry, R. E. ----------Iron Mountain, Michigan
Bleckwenn, W. J. ----------Winter Haven, Florida
Block, R. M. ----------San Diego, California
Bremer, E. M. ----------North Ridge, California
Brown, W. M., Jr. ----------Altadena, California
Childers, G. A. ----------Coral Gables, Florida
Cleveland, D. A. ----------Palm Springs, California
Costello, W. H. ----------Phoenix, Arizona
Cramer, G. G. ----------Minneapolis, Minnesota
Davee, Chalmer ----------Columbia, South Carolina
Deering, H. C. ----------Norwalk, California
Dierker, O. F. ----------Bradenton, Florida
Doyle, R. F. ----------Wadsworth, Kansas
Duer, G. R. ----------Winter Haven, Florida
Feldman, E. I. ----------Beverly Hills, California
Fink, J. N. ----------Evanston, Illinois
Goodfriend, R. B. ----------Daly City, California
Grace, E. V. ----------Durham, North Carolina
Grinvalsky, H. T. ----------Omaha, Nebraska
Gunderson, D. E. ----------Cincinnati, Ohio
Habermann, J. H. ----------Denver, Colorado
Hansen, R. L. ----------Rochester, Minnesota
Harter, A. F. ----------Eveleth, Minnesota
Hartwick, J. P. ----------Fort McClellan, Alabama
Haugh, T. G. ----------New Berry, Michigan
Heeb, H. J. ----------Howley in the Hills, Florida
Hoehne, K. A. ----------Manteno, Illinois
Hogan, John ----------Campbellsville, Kentucky
Hultman, C. A. ----------Helena, Montana
Huth, E. P. ----------Englewood, Florida
Jascula, J. H. ----------San Francisco, California
Jaques, D. A. ----------El Paso, Texas
Johnson, H. C. ----------Eugene, Oregon
Jones, W. P. ----------Honolulu, Hawaii
Kearns, W. M. ----------Pompano Beach, Florida
Kelley, G. F. ----------Berkeley, California
Klein, T. W. ----------Marathon, Florida
Klumper, Wilhelm ----------Cherokee, Iowa
Knight, C. C. ----------Hollywood, California
Korkos, G. J. ----------St. Louis, Missouri
Krueger, E. N. ----------San Bernardino, California
Lee, J. M. ----------San Diego, California
Lende, R. A. ----------Denver, Colorado
Lindner, Anton ----------Oklahoma City, Oklahoma
Lyne, B. W. ----------Rochester, Minnesota
MacGillis, A. J. ----------Rochester, New York
Maloney, C. G. ----------National City, California
Marks, J. R. ----------Tumwater, Washington
Metcalf, G. S. ----------Lewiston, Idaho
Middleton, W. S. ----------Oklahoma City, Oklahoma
Monson, S. D. ----------Minneapolis, Minnesota
Mulvaney, J. J. ----------Traverse City, Michigan
Neal, M. P., Jr. ----------Richmond, Virginia
Nickels, R. J. ----------Saginaw, Michigan
O'Donnell, M. J. ----------Wadsworth, Kansas
Pember, A. H. ----------Lake Wales, Florida
Peterson, F. N. ----------Wayland, Massachusetts
Randall, M. W. ----------Glenwood Springs, Colorado
Reeck, L. K. ----------Tucson, Arizona
Richany, S. F. ----------Durham, North Carolina
Roemer, E. P. ----------San Marino, California
Roller, M. C. ----------Whiteland, Indiana
Rosmann, H. K. ----------Winnetka, Illinois
Rothe, C. A., Jr. ----------Omaha, Nebraska
Royce, M. E. ----------Honokaa, Hawaii
Sargeant, H. W. ----------Long Prairie, Minnesota
Saydjari, M. S. ----------Wetumka, Oklahoma
Schultz, C. L. ----------Spokane, Washington
Scribner, L. F., Jr. ----------Cazenovia, New York
Sievert, R. A. ----------River Edge, New Jersey
Simenstad, J. O. ----------St. Paul, Minnesota
Stebbins, W. W. ----------St. Petersburg, Florida
Tabet, R. C. ----------Toledo, Ohio
Templeton, H. M. ----------Elgin, Illinois
Theil, G. B. ----------Fremont, California
Van Kirk, F. W., Sr. ----------San Francisco, California
Van Riper, H. E. ----------Yonkers, New York
Vanstane, V. R. ----------Whitesville, West Virginia
Von Ruden, W. J. ----------Burlingame, California
Way, T. F. ----------Merced, California
Wells, M. R. ----------Belleville, Illinois
Werba, D. R. ----------Phoenix, Arizona
Weston, E. L. ----------Academy, Colorado
White, E. F. ----------Harlingen, Texas
Winkler, H. A. ----------Denver, Colorado
Zabors, T. E. ----------Los Angeles, California
Zaun, J. J., Jr. ----------Mesa, Arizona

Honorary Members

Bradley, H. C. Ph.D.----------Berkeley, California
Clark, P. F., Ph.D.----------Madison, Wisconsin
Foerster, O. H.----------Milwaukee, Wisconsin
Hardman, H. F. ----------Milwaukee, Wisconsin
Hunter, A. L. ----------Madison, Wisconsin
McCracken, R. W.----------Union Grove, Wisconsin
McMahon, H. O.----------Milwaukee, Wisconsin
Miller, E. W.----------Milwaukee, Wisconsin
Mortensen, O. A.----------Madison, Wisconsin
Morton, Silvanus A.----------Beirut, Lebanon
Pusey, W. A., Ph.D.----------Chicago, Illinois
Shideman, F. E.----------Minneapolis, Minnesota
Sisk, I. R.----------Madison, Wisconsin
Sullivan, W. E., Ph.D.----------Claremont, California

Members Serving in the Armed Forces

Brown, R. C. ---------APO 282, New York, New York
Bukosky, R. J. ----------Linden, New Jersey
Bultema, J. H. ----------Muskegon, Michigan
Chapman, M. J. ----------Bethesda, Maryland
Chisholm, D. E. ----------Kenosha, Wisconsin
Collins, J. D. ----------Carswell AFB, Texas
Enders, L. J. ----------Otis AFB, Massachusetts
Goldbeck, L. O. ----------San Francisco, California
Goldberger, R. J ---------Vandenberg AFB, California
Gordon, J. J. ----------Johnsonville, Pennsylvania
House, J. W., Jr. ------Fort Leonard Wood, Missouri
Kinsey, J. L. ----------Washington, D. C.
Kirchner, M. M. ---------Fort Jackson, South Carolina
Korbitz, B. C. ----------Randolph AFB, Texas
Kratchovil, C. H. ---------Holloman AFB, New Mexico
Kreissl, L. J. ----------Santa Rosa, California
Kroncke, G. M. ---------FPO, San Francisco, California
Lasser, A. E. ----------Cincinnati, Ohio
Liske, E. A. ----------Brooks, AFB, Texas
Locksmith, J. P. ----------Ferguson, Missouri
Maloney, J. D. ----------Columbus, Ohio
Martens, T. J. ---------APO, San Francisco, California
McCabe, L. B. ---------P. O. 757, New York, New York
Pettera, R. L. ----------Tacoma, Washington
Rammer, M. A., Jr. ----APO 28, New York, New York
Rapkin, M. A. ----------Rantoul, Illinois
Roberts, G. W. ----------Shephard AFB, Texas
Ruf, D. F. ----------Darlington, Wisconsin
Schatz, W. R. ----------Modesto, California
Schmidt, C. H. ----------Bellevue, Nebraska
Schmidt, R. D. ---------Ellsworth AFB, South Dakota
Scrimenti, R. J. ----------Guantanamo Bay, Cuba
Taylor, C. A., Jr. ----------Atlanta, Georgia
Valaske, M. J. ----------San Diego, California
Werra, R. J. ----------Ukiah, California
Woods, S. M. ----------Van Nuys, California

Foreign Members

Bowers, J. Z. ----------Kyoto, Japan
Grant, L. C., Jr. ----------Nigeria, West Africa
Harkness, J. W. ----Peace Corps, Manila, Philippines
Horning, J. S. ----------Quito, Ecuador
Jensen, Alfhild ----------Puli, Taiwan
Olsen, V. B. ----------Chittagong, East Pakistan
Schlaepfer, K. ----------Cuernavaca, Morelos, Mexico
Torbey, Peter ----------Gothemberg, Sweden

Life Members

Bauer, K. T.----------West Bend
Beck, A. A.----------Wautoma
Beebe, S. D.----------Sparta
Bornstein, Max----------Milwaukee
Brunckhorst, F. O.----------Neenah
Campbell, W. B.----------Waukesha
Christensen, F. C.----------Racine
Clark, W. T.----------Janesville
Connell, F. G.----------Oshkosh
Crockett, W. W.----------Beloit
*Dailey P. J.----------Elcho
Eck, G. E. ----------Lake Mills
Epley, O. H.----------New Richmond
Fazen, L. E.----------Racine
Fechter, F. J. ----------Milwaukee
Forkin, G. E.----------Menasha
Gramling, J. J.----------Milwaukee
Hammond, F. W.----------Manitowoc
Heeb, H. J.----------Howley in the Hills, Florida
Herner, Wm. L. ----------Milwaukee
Holbrook, A. T.----------Milwaukee
Hogan, John H.----------Racine
Kay, H. M.----------Madison
*Keland, H. B.----------Racine
Kleinboehl, J. W.----------Mercer
Knutson, Oscar----------Osseo
Kradwell, W. T. ----------Wauwatosa
Leonard, C. W.----------Fond du Lac
Levitas, I. E.----------Green Bay
Lockhart, C. W.----------Mellen
Ludden, H. D.----------Mineral Point
Lumsden, William----------Menomonie
Marshall, V. F.----------Appleton
Moore, L. A.----------Monroe
*Morton, H. H.----------Dodgeville
Nauth, D. F.----------Kiel
Pope, F. W.----------Racine
Potter, R. P.----------Marshfield
Rolfs, T. H.----------Milwaukee
Schmit, Louis----------Milwaukee
*Schweitzer, G. J.----------Milwaukee
Stebbins, W. W.----------St. Petersburg, Florida
Stemper, Irene T.----------Oconomowoc
Tasche, C. T.----------Sheboygan
Thomas, W. O.----------Clinton
Towne, W. H.----------Hortonville
Twohig, D. J.----------Fond du Lac
Van Kirk, F. W.----------San Francisco, California
*Waldschmidt, W. J.----------Fond du Lac
Washburn, R. G. ----------Milwaukee
Wetzler, S. H.----------Milwaukee
Ziegler, John E. B.----------Eau Claire

* Granted life membership in 1963.

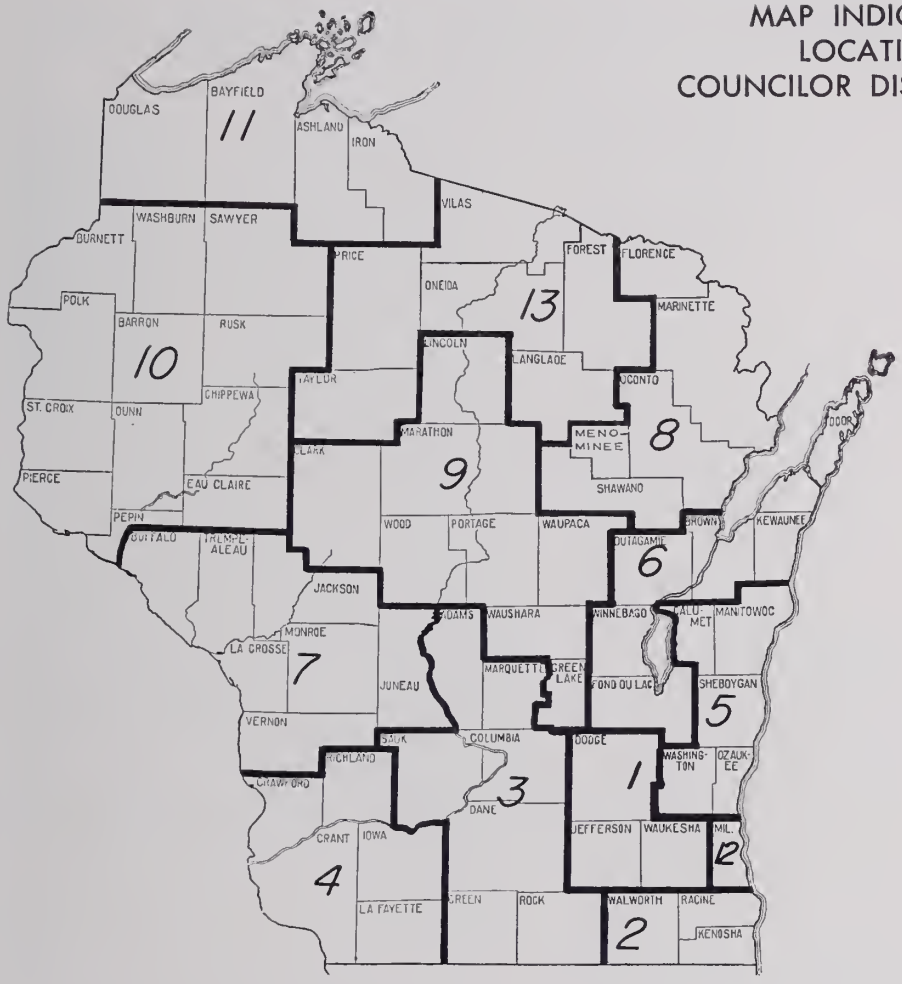
ATTENUATED MEASLE VACCINE

A new page is being written in the story of Immunology with the recent approval for release of attenuated measle vaccine. This vaccine has been under clinical study for approximately four years and has proved highly effective in the prevention of measles.

The procedure for its use recommended by the U.S. Public Health Service and the American Academy of Pediatrics is administration of the live attenuated virus vaccine in one syringe followed immediately by administration of gamma globulin in a dosage of 0.01 cc. per pound of body weight in a second syringe. While the use of gamma globulin reduces moderately the immunological reaction to the virus, it is felt advisable because of the marked reduction in number and severity of reactions produced. Using this procedure about 25 per cent of the children may have a moderate reaction with fever and occasionally with rash occurring between 5 and 12 days following vaccination. Because of interference by maternally produced antibodies, it is recommended that the measle vaccine not be utilized prior to the age of nine months. Since the vaccine is prepared by growth in chick embryos, it should be used with caution in individuals highly allergic to egg protein.

In view of the high number of complications following measles, the Division on Maternal and Child Welfare of the Commission on State Departments of the State Medical Society and the State Health Department highly recommend a statewide program for immunization of susceptible individuals. At the present time there are no plans for public clinics and thus active promotion in the office of each physician is indicated.—Prepared for Division on Maternal and Child Welfare by Kenneth C. Mickle, M.D. and Stewart L. Griggs, M.D., Green Bay, December 1963.

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



COUNCILORS:

FIRST DISTRICT:
W. D. James, M.D., Oconomowoc

SECOND DISTRICT:
G. J. Schulz, M.D., Union Grove

THIRD DISTRICT:
E. J. Nordby, M.D., Madison
C. W. Stoops, M.D., Madison
M. D. Davis, M.D., Milton

FOURTH DISTRICT:
E. M. Dessloch, M.D., Prairie du Chien

FIFTH DISTRICT:
P. B. Blanchard, M.D., Cedarburg

SIXTH DISTRICT:
H. J. Kief, M.D., Fond du Lac
George Nadeau, M.D., Green Bay

SEVENTH DISTRICT:
J. C. Fox, M.D., La Crosse

EIGHTH DISTRICT:
J. M. Bell, M.D., Marinette

NINTH DISTRICT:
R. W. Mason, M.D., Marshfield

TENTH DISTRICT:
R. C. Frank, M.D., Eau Claire

ELEVENTH DISTRICT:
V. E. Ekblad, M.D., Superior

TWELFTH DISTRICT:
L. J. Van Hecke, M.D., Milwaukee
W. J. Houghton, M.D., Milwaukee
D. M. Willson, M.D., Milwaukee
S. L. Chojnacki, M.D., Milwaukee
S. W. Hollenbeck, M.D., Milwaukee

THIRTEENTH DISTRICT:
Marvin Wright, M.D., Rhinelander

Officers and Councilors 1963-1964

State Medical Society of Wisconsin

OFFICERS OF THE SOCIETY

PRESIDENT_____W. J. Egan, M.D., Milwaukee
720 North Jefferson Street

PRESIDENT-ELECT_____W. P. Curran, M.D., Antigo
Box 420

SECRETARY_____Mr. C. H. Crownhart, Madison
330 East Lakeside Street

ASSISTANT SECRETARY__Mr. Roy T. Ragatz, Madison
330 East Lakeside Street

TREASURER_____F. L. Weston, M.D., Madison
1 South Pinckney Street

SPEAKER_____Robert E. Callan, M.D., Milwaukee
1733 West Wisconsin Avenue

VICE-SPEAKER_____H. W. Carey, M.D., Lancaster
257 Madison Street

COUNCILORS

(J. C. Fox, M.D., La Crosse, Chairman)
(J. M. BELL, M.D., Marinette, Vice-chairman)

DISTRICTS*

FIRST: Dodge, Jefferson and Waukesha County Societies. W. D. James, M.D., 340 Summit Avenue, Oconomowoc, 1966.

SECOND: Kenosha, Racine and Walworth County Societies. G. J. Schulz, M.D., 722 15th Avenue, Union Grove, 1966.

THIRD: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. E. J. Nordby, M.D., 2715 Marshall Court, Madison, 1964; M. D. Davis, M.D., 309 College Street, Milton, 1965; C. W. Stoops, M.D., 110 East Main Street, Madison, 1966.

FOURTH: Crawford, Grant, Iowa, Lafayette and Richland County Societies. E. M. Dessloch, M.D., Medical Park, Prairie du Chien, 1964.

FIFTH: Calumet, Manitowoc, Sheboygan, Washington and Ozaukee County Societies. P. B. Blanchard, M.D., 204 North Washington Avenue, Cedarburg, 1964.

SIXTH: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. H. J. Kief, M.D., 104 South Main Street, Fond du Lac, 1964; George Nadeau, M.D., 128 East Walnut Street, Green Bay, 1965.

SEVENTH: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. J. C. Fox, M.D. (Chairman), 212 South Eleventh Street, La Crosse, 1965.

EIGHTH: Marinette–Florence, Oconto, and Shawano County Societies. J. M. Bell, M.D. (Vice-chairman), 516 Houston Street, Marinette, 1965.

NINTH: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. R. W. Mason, M.D., 650 South Central Avenue, Marshfield, 1965.

TENTH: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. R. C. Frank, M.D., 550 North Dewey Street, Eau Claire, 1965.

ELEVENTH: Ashland–Bayfield–Iron and Douglas County Societies. V. E. Ekblad, M.D., 1507 Tower Avenue, Superior, 1966.

TWELFTH: The Medical Society of Milwaukee County. L. J. Van Hecke, M.D., 161 West Wisconsin Avenue, Milwaukee, 1966; W. J. Houghton, M.D., 2943 North Oakland Avenue, Milwaukee, 1966; D. M. Willson, M.D., 2618 East Shorewood Blvd., Milwaukee, 1964; S. L. Chojnacki, M.D., 3122 South Thirteenth Street, Milwaukee 15, 1965; S. W. Hollenbeck, M.D., 2650 West Fond du Lac Avenue, Milwaukee 6, 1965.

THIRTEENTH: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Marvin Wright, M.D., 1020 Kabel Avenue, Rhinelander, 1965.

PAST PRESIDENT _____N. A. Hill, M.D., Madison
304 West Washington Avenue

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

A. A. Quisling, M. D. (1965)_____Madison
2 West Gorham Street

R. E. Galasinski, M.D. (1965) _____Milwaukee
3333 South 27th Street

John M. Bell, M.D. (1964)_____Marinette
516 Houston Street

E. L. Bernhart, M.D. (1964)_____Milwaukee
2714 West Burleigh Street

Alternates

W. B. Hildebrand, M.D. (1965) _____Menasha
59 Racine Street

George Collentine, Jr., M.D. (1965) ____Milwaukee
2266 North Prospect Avenue

J. C. Fox, M.D. (1964) _____La Crosse
212 South Eleventh Street

C. J. Picard, M.D. (1964)_____Superior
425 Twenty-first Avenue East

* Map indicating location of councilor districts, page 91.

Note: Officers, councilors, delegates and members of Standing Committees are elected at the Annual Meeting in May.

Standing Committees—1963-1964

State Medical Society of Wisconsin

COMMITTEE ON CANCER

G. I. Uhrich, M. D.
Chairman

G. I. Uhrich, M.D. (1965) ---------- La Crosse
212 South Eleventh Street

J. W. Boren, Jr., M.D. (1964) ---------- Marinette
1510 Main Street

M. W. Stuessy, M.D. (1964) ---------- Brodhead
605 East Fourth Avenue

G. H. Williams, M.D. (1964) ---------- Marshfield
Marshfield Clinic

Ralph C. Frank, M.D. (1965) ---------- Eau Claire
550 North Dewey Street

R. C. Glise, M.D. (1965) ---------- Richland Center
118 West Mill Street

G. A. Smiley, M.D. (1965) ---------- Delavan
107 North Third Street

J. J. Gramling, Jr., M.D. (1965) ---------- Milwaukee
324 East Wisconsin Avenue

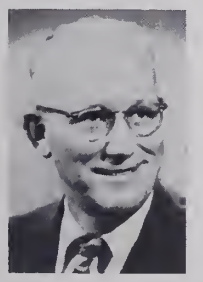
J. F. Brown, M.D. (1965) ---------- Rhinelander
1020 Kabel Avenue

J. R. Hoon, M.D. (1966) ---------- Sheboygan
1011 North 8th Street

William Reed, M.D. (1966) ---------- Watertown
113 North Third

J. E. Dettmann, M.D. (1966) ---------- Green Bay
519 South Monroe

J. G. Telford, M.D. (1966) ---------- Washburn



COMMITTEE ON GRIEVANCES

E. D. Sorenson, M.D.
Chairman

E. D. Sorenson, M.D. (1965) ---------- Elkhorn
Chairman 104 South Wisconsin Street

M. F. Huth, M.D. (1966) ---------- Baraboo
203 Fourth Street

Donald K. Griffith (1966) ---------- Eau Claire
Midelfart Clinic

J. D. Leahy, M.D. (1966) ---------- Park Falls
170 Fourth Avenue North

H. J. Belson, M.D. (1964) ---------- Manitowoc
904A South Eighth Street

R. R. Richards, M.D. (1964) ---------- Eau Claire
605 Walker Avenue

T. J. Nereim, M.D. (1964) ---------- Madison
333 Glen Way

E. W. Mason, M.D. (1965) ---------- Milwaukee
324 East Wisconsin Avenue

R. W. Mason, M.D. (1965) ---------- Marshfield
650 South Central Avenue

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. E. Dorchester, M.D.
Chairman

D. E. Dorchester, M.D. (1966) ---------- Sturgeon Bay
Chairman 10 North Third Avenue

J. E. Martin, Jr., M.D. (1966) ---------- Delavan
607 Walworth Avenue

R. J. Botham, M.D. (1966) ---------- Madison
1313 Fish Hatchery Road

J. S. Devitt, M.D. (1964) ---------- Milwaukee
2243 N. Prospect Avenue

Louis Olsman, M.D. (1964) ---------- Kenosha
625 57th Street

C. A. Olson, M.D. (1964) ---------- Baldwin

C. J. Picard, M.D. (1965) ---------- Superior
425–21st Avenue, East

D. G. MacMillan, M.D. (1965) ---------- Barron
1220 Woodland

W. E. Acheson, M.D. (1965) ---------- Valders
Liberty Street

COMMISSION ON PUBLIC POLICY

R. G. Zach, M.D.
Chairman

Robert G. Zach, M.D. (1967) ---------- Monroe
Chairman 810–19th Avenue

W. T. Russell, M.D. (1966) ---------- Sun Prairie
Vice-chairman 215 East Main Street

H. E. Oppert, M.D. (1967) ---------- Viroqua
318 South Main Street

Earl C. Quackenbush, M.D. (1967) ---------- Hartford
14 North Main Street

C. F. Broderick, M.D. (1968) ---------- Wisconsin Dells
Box 325

Norbert Enzer, M.D. (1964) ---------- Milwaukee
948 North Twelfth Street

L. J. Kurten, M.D. (1965) ---------- Racine
810 Main Street

President, ex officio
President-elect, ex officio
Secretary, ex officio

COMMISSION ON SCIENTIFIC MEDICINE

A. R. Curreri, M. D.
Chairman

A. R. Curreri, M.D. (1964) ---------- Madison
Chairman 1300 University Avenue

J. K. Curtis, M.D. (1967) ---------- Madison
2500 Overlook Terrace

P. T. Bland, M.D. (1965) ---------- Westby
107 North Main Street

G. E. Collentine, Jr., M.D. (1966) ---------- Milwaukee
2266 North Prospect Avenue

T. V. Geppert, M.D. (1968) ---------- Madison
1313 Fitchburg Road

Victor S. Falk, Jr., M.D. ---------- Edgerton
5 W. Rollin Street

John S. Hirschboeck, M.D. ---------- Milwaukee
561 North Fifteenth Street

* * *

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Chairman of the Council, Chairman
Immediate Past President
President
President-elect
Secretary

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

G. B. Murphy, Jr., M. D.
Chairman

G. B. Murphy, Jr., M.D. (1964) ---------- La Crosse
Chairman 1836 South Avenue

C. J. Picard, M.D. (1964) ---------- Superior
425–21st Avenue, East

Edgar End, M.D. (1964) ---------- Wauwatosa
7608 West State Street

T. H. McDonell, M.D. (1965) ---------- Waukesha
217 Wisconsin Avenue

S. L. Henke, M.D. (1966) ---------- Eau Claire
314 Grand Avenue

H. G. Bayley, M.D. (1966) ---------- Beaver Dam
116 Iroquois Parkway

M. V. Overman, M.D. (1965) ---------- Neillsville
Neillsville Clinic

A. J. Richtsmeier, M.D. (1965) ---------- Madison
110 East Main Street

P. C. Dietz, M.D. (1966) ---------- La Crosse
1020 Market Street

John S. Hirschboeck, M.D., Marquette University School of Medicine ---------- Milwaukee
Ex officio 561 North Fifteenth Street

* * *

COUNCIL COMMITTEES

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finance
Planning
Scientific Medicine

Council Committees:

Clinical Medicine
Disaster Medical Care
Commission on Medical Care Plans
Commission on State Departments
Editorial Board
Military Medical Service
Health Economics of American Life (HEAL)

COMPONENT COUNCIL COMMITTEES 1963–1964

(Appointed by the Chairman of the Council and composed of members of the Council)

EXECUTIVE COMMITTEE

James C. Fox, M.D._____La Crosse
Chairman of the Council
212 South 11th Street

J. M. Bell, M.D._____Marinette
Chairman, Scientific Medicine
516 Houston Street

Ralph C. Frank, M.D._____Eau Claire
Chairman, Planning
550 North Dewey Street

E. M. Dessloch, M.D.__Prairie du Chien
Chairman, Finance

L. J. Van Hecke, M.D._____Milwaukee
Chairman, Scientific Medicine
6001 West Center Street

E. J. Nordby, M.D._____Madison
Chairman, Economic Medicine
2715 Marshall Park

Ex officio: W. J. Egan, M.D., president
_____Milwaukee
Chairman
720 North Jefferson Street

N. A. Hill, M.D., past president
_____Madison
304 West Washington Avenue

W. P. Curran, M.D., president-elect
_____Antigo
Box 420

SCIENTIFIC MEDICINE

L. J. Van Hecke, M.D._____Milwaukee
Chairman
6001 West Center Street

H. J. Kief, M.D._____Fond du Lac
104 South Main Street

C. W. Stoops, M.D._____Madison
110 East Main Street

W. J. Houghton, M.D._____Milwaukee
2943 North Oakland Avenue

S. W. Hollenbeck, M.D._____Milwaukee
2650 West Fond du Lac Avenue

ECONOMIC MEDICINE

E. J. Nordby, M.D._____Madison
Chairman
2715 Marshall Court

P. B. Blanchard, M.D._____Cedarburg
204 North Washington Avenue

G. J. Schulz, M.D._____Union Grove
722 15th Avenue

Marvin Wright, M.D._____Rhinelander
1020 Kabel Avenue

George Nadeau, M.D._____Green Bay
128 East Walnut Street

PLANNING

Ralph C. Frank, M.D._____Eau Claire
Chairman
550 North Dewey Street

R. W. Mason, M.D._____Marshfield
Marshfield Clinic

Milton D. Davis_____Milton
309 College Street

D. M. Willson, M.D._____Milwaukee
2618 East Shorewood Boulevard

H. J. Kief, M.D._____Fond du Lac
104 South Main Street

FINANCE

E. M. Dessloch, M.D.__Prairie du Chien
Chairman
Medical Park

E. J. Nordby, M.D._____Madison
2715 Marshall Court

W. D. James, M.D._____Oconomowoc
340 Summit Avenue

Ralph C. Frank, M.D._____Eau Claire
550 North Dewey Street

J. M. Bell, M.D._____Marinette
516 Houston Street

S. L. Chojnacki, M.D._____Milwaukee
3122 South 13th Street

Ex officio: F. L. Weston, M.D.,
Treasurer_____Madison
One South Pinckney Street

Note: Chairman Fox is an ex-officio member of the last four committees.

OFFICERS OF SCIENTIFIC SECTIONS OF THE STATE MEDICAL SOCIETY

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(Appointed by the Chairman of the Council and composed of members of the State Medical Society)

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80 Sheboygan Street

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1313 Fish Hatchery Road

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7—J. R. Heersma, M.D.__Marshfield
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316 Main Street

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E. M. Dessloch, M.D. (1964)
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Chairman
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Suite 604, Zuelke Bldg.

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_____ Kenosha
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A. W. Hilker, M.D. (1964)
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314 Grand Avenue East

P. B. Mason, M.D. (1964)__Sheboygan
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2715 Marshall Court

L. O. Simenstad, M.D. (1964)_Osceola
195 Hammond Street

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_____Box 325, Wisconsin Dells

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W. T. Casper, M.D., (1965)_Milwaukee
5325 W. Burleigh Street

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109 E. Johnson Street

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President-elect Curran

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Aging
20 Forest Avenue

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Maternal & Child Welfare
208 East Wisconsin Avenue

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1200 South Quincy

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257 No. Madison Street

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Chest Diseases

L. M. Simonson, M.D.____Sheboygan
School Health
1011 No. 8th Street

Meyer S. Fox, M.D._____Milwaukee
Visual & Hearing Defects
2040 W. Wisconsin Avenue

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Rehabilitation
6541 Washington Circle

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NEWER CONCEPTS AND TECHNIQUES IN GASTROINTESTINAL DISEASE

University of Wisconsin Postgraduate Program—Feb. 27–29, 1964

Wisconsin Center, located on the corner of Lake and Langdon streets
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Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, M.D.†	1930
Cornelius A. Harper, M.D.†	1930
John J. McGovern, M.D.†	1931
Louis M. Jermain, M.D.†	1931
Edward Evans, M.D.†	1931
Mina B. Glasier, M.D.†	1932
Arthur W. Rogers, M.D.†	1934
Rock Sleyster, M.D.†	1934
Olin West, M.D.†	1934
Edward A. Birge, Ph.D.†	1935
Arthur J. Patek, M.D.†	1935
Joseph F. Smith, M.D.†	1937
Eben J. Carey, M.D.†	1938
William S. Middleton, M.D.	1938
Fred G. Johnson, M.D.†	1939
William D. Stovall, M.D.	1940
Ludvig Hektoen, M.D.*†	1941
Stephen E. Gavin, M.D.†	1944
F. Gregory Connell, M.D.	1947
E. R. Schmidt, M.D.†	1949
Armand J. Quick, M.D.	1950
F. A. Stratton, M.D.†	1951
Gunnar Gundersen, M.D.	1953
W. J. Meek, Ph.D.†	1953
R. G. Arveson, M.D.†	1957
Edwin B. Fred, Ph.D.	1958
Harry Beckman, M.D.	1959
Elizabeth Comstock, M.D.	1961
Harry Steenbock, Ph.D.	1963

* Centennial Award. † Deceased.

Recipients of the Presidential Citation

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a nonphysician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission	1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library)	1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University)	1963

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 207 East Michigan Street, Milwaukee 2.

Catholic Welfare Agency, 1209 Hughitt Ave., Superior.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse.

Catholic Welfare Bureau, 25 S. Hancock, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 13.

Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

PUBLIC AGENCIES:

*Wisconsin Division for Children and Youth, Room 385, State Office Bldg., Madison 2.

*Milwaukee County Department of Public Welfare, Child Welfare Division, County Court House, Milwaukee 3.

LICENSED MATERNITY HOMES:

Infant of Prague Maternity Home (Catholic), 304 Front Street East, Ashland.

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 1233 North 23rd Street, Milwaukee 3.

St. Francis Hospital (Catholic), 1020 Market Street, La Crosse (temporarily closed due to a building program).

St. Mary's Home (Catholic), 435 South Webster Avenue, Green Bay.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favill, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952
J. C. Griffith, Milwaukee 1953
H. Kent Tenney, Madison 1954
Arthur J. McCarey, Green Bay*** 1955
Ervin L. Bernhart, Milwaukee 1956
L. O. Simenstad, Osceola 1957
Harry E. Kasten, Beloit 1958
Jerome W. Fons, Milwaukee**** 1958
W. B. Hildebrand, Menasha 1960
E. D. Sorenson, Elkhorn 1961
L. H. Lokvam, Kenosha 1962
N. A. Hill, Madison 1963

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.
**** Resigned during term of office.

The State Medical Society of Wisconsin

ORGANIZED 1841

W. J. EGAN, Milwaukee, President
W. P. CURRAN, Antigo, President-Elect
R. E. CALLAN, Milwaukee, Speaker

H. W. CAREY, Lancaster, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

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J. M. BELL, Marinette, Vice-Chairman

Term Expires 1966

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1965

Third District:
M. D. Davis.....Milton

Term Expires 1964

E. J. Nordby.....Madison

Term Expires 1966

C. W. Stoops.....Madison

Term Expires 1964

Fourth District:
E. M. Dessloch.....Prairie du Chien

Term Expires 1964

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
H. J. Kief.....Fond du Lac

Term Expires 1965

George Nadeau.....Green Bay

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

Eighth District:
J. M. Bell.....Marinette
(Vice-chairman)

Ninth District:
R. W. Mason.....Marshfield

Tenth District:
R. C. Frank.....Eau Claire

Term Expires 1966

Eleventh District:
V. E. Ekblad.....Superior

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1964

D. M. Willson.....Milwaukee

Term Expires 1965

S. L. Chojnacki.....Milwaukee
S. W. Hollenbeck.....Milwaukee

Thirteenth District:
Marvin Wright.....Rhinelander

Term Expires 1964

N. A. Hill.....Madison
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

John M. Bell, Marinette, 1964

E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1965

A. A. Quisling, Madison, 1965

Alternates

J. C. Fox, La Crosse, 1964

C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1965

W. B. Hildebrand, Menasha, 1965

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Wm. Smiles 522 W. 2nd St., Ashland	C. A. Crand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	H. O. Jirsa Cumberland	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	L. H. Edelhlute 744 S. Webster Green Bay	Frank Urhan Rm. 308, City Hall, Creen Bay	Second Thursday*
Calumet	K. R. Humke Chilton	R. E. Knauf Chilton	
Chippewa	Charles A. Kemper 727 Maple, Chippewa Falls	James L. Windeck 600 Bay St., Chippewa Falls	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Cungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Carrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	Palmer R. Kundert 110 E. Main St., Madison	Gordon Davenport, Jr. 110 E. Main, Madison	Second Tuesday**
Dodge	Norman Erickson 302 N. Spring St., Beaver Dam	N. H. Schulz 317 E. Lake St., Horicon	Last Thursday*
Door–Kewaunee	W. S. Hohson 25 S. Madison, Sturgeon Bay	David Papendick 801 Fourth St., Algoma	
Douglas	Thomas J. Doyle 1507 Tower Ave., Superior	Oscar Farias Hawthorne	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	Harold Kief 104 So. Main St. Fond du Lac	W C. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Waheno	D. V. Moffet, Crandon	
Crant	C. L. Steidinger Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Creen	John M. Irvin 2101 6th St., Monroe	Frank C. Stiles 921 16th Ave., Monroe	
Creen Lake–Waushara	Russell C. Darby Wautoma	Roy Hong Wild Rose	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	E. J. Hohler Mineral Point	H. P. Breier Montfort	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Ave. Watertown	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	C. A. Sattler 6401 Sheridan Rd., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	Frederick H. Wolf 419 Main St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	Earl J. Roth 606 Superior, Antigo	First Monday
Lincoln	J. D. Millenbah 121 S. Mill St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	Charles E. Wall 904 South 8th St. Manitowoc	G. H. Stannard, Jr. Holy Family Hospital Manitowoc	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	Charles Koepp 516 Houston St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Robert S. Haukohl 620 N. 19th St., Milwaukee	Donald P. Babbitt 2701 E. Beverly Rd., Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	Michael Barton 907 Main St., Oconto	
Oneida–Vilas	Allen Johnson Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	F. M. Hauch 722 W. Lawrence St., Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday* Elks Club
Ozaukee	Kenneth F. Pelant 1240 13th Ave., Grafton	Allen Misch 204 N. Washington Ave., Cedarburg	
Pierce–St. Croix	Ernest Drury New Richmond	P. H. Gutzler River Falls	Third Tuesday
Polk	Lloyd Olson St. Croix Falls	Paul Simenstad Osceola	Third Thursday 7:00 p.m.
Portage	R. H. Slater 401 Main St., Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	Frank J. Scheible 632 High St., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	George Parke, Jr. 323 So. Central Ave., Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	R. M. Baldwin 419 W. Pleasant St., Beloit	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	I. A. Galarynk Plain	Gibbs W. Zauft 590 4th St., Prairie du Sac	Second Tuesday*
Shawano	H. F. Laufenberg Shawano	A. J. Sebesta 126½ S. Main St., Shawano	Third Wednesday
Sheboygan	Donald M. Rowe Kohler	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Albert Daniells R #1., Arcadia	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Joseph Syty Viroqua	C. A. Ender 120 W. Court St., Viroqua	Last Wednesday
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THE PRESIDENT'S PAGE . . .

Safety Conscious

■ AS ONE WHO has been deeply interested in all phases of community safety, I would like to call your attention to the 1963 edition of *Wisconsin Accident Facts,* published by the Wisconsin Motor Vehicle Department under the direction of Commissioner James L. Karns. This edition contains information on the types and circumstances of traffic accidents occurring in 1962 and is based on accident reports submitted by law enforcement agencies in compliance with Wisconsin statutes.

This edition is the best that I have ever seen, and because of the concisely lucid manner in which all facts, data, and principles are presented, every physician and every member of the professional health team should be interested in its contents. A number of State Medical Society committees devote part of their efforts toward solving medical problems involving safety. Your president, too, has been secretary of the Milwaukee Safety Commission for a number of years.

A summary of the statistical information in *Wisconsin Accident Facts* follows:

The 1962 Traffic Accident Toll and Its Causes

In 1962 an all-time record for deaths in traffic was set in Wisconsin, with 956 fatalities surpassing the former high of 955 deaths in 1956. (According to the Motor Vehicle Department, the fatality toll from motor vehicle traffic accidents in 1963 reached 908. This was the seventh year in which the toll exceeded the 900 mark.) The number of people who survived traffic accidents though injured also reached a new high, piercing the 34,000 "barrier" for the first time. In all, 1962 was a desolate year in Wisconsin's motoring history, with more traffic accidents of all kinds than ever before.

Although the extent of traffic accident occurrence reached new proportions, the apparent causes of most accidents were old and familiar ones:

- Most of the drivers involved in accidents were breaking the law at, or immediately before, the time of the accident.
- The most common violations associated with 1962 traffic accidents were: Speed—too fast for conditions; failure to yield right of way; drinking and driving; failure to stay in correct traffic lane; following too closely; executing turns improperly; passing improperly; disregarding stop signs or signals.

Most of these violations reveal an irresponsible attitude on the part of the driver, others suggest lack of knowledge, or insufficient skill on the

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PRESIDENT'S PAGE *continued from page 105*

driver's part. In some cases the fatal faults seem to go hand-in-hand.

The chief purpose in tabulating and publishing the facts found in this booklet is to enable the persons who study it—officials, educators, enforcers, engineers, community leaders, individual citizens—to learn more about the nature of Wisconsin's accident problem. It is hoped that this knowledge will not only awaken or renew their interest in accident prevention, but will point the direction in which their safety promotion efforts may most profitably be expended.

Did You Know . . .

- 956 persons were killed in Wisconsin motor vehicle traffic accidents during 1962, establishing an all time record high. The second highest toll was 955 deaths in 1956 and third highest was 932 deaths in 1955.
- One person was killed in Wisconsin traffic accidents every 9.2 hours during 1962. In 1961, one person was killed every 9.6 hours.
- 31% of persons killed in Wisconsin traffic accidents in 1962 were in the 16–25 age group.
- It is estimated that 15,100 years of life were lost by persons killed in the 16–25 age group in 1962.
- 75% of persons killed in Wisconsin traffic accidents in 1962 were males.
- 34,275 persons were injured in 22,192 reported injury accidents.
- Over 15.7 billion miles were traveled in Wisconsin highways last year, an increase of 1% over 1961 and 37% over 1952.
- 70% of the drivers involved in fatal accidents were operating in violation of traffic laws.
- In 1962, 33% of all pedestrians killed were age 65 and over, 29% were age 14 and under.
- Of 71,848 accidents reported to the department, 78 were fatal accidents, 22,192 were injury accidents, and 48,867 were property damage accidents.
- In 1962 estimated economic costs of Wisconsin traffic accidents exceeded $170,000,000.
- Total accidents reported in 1962 (police-reporting) show an increase of 13.2% over 1961 (driver-reporting).
- 54% of all rural accidents occur on State Highways, 21% on County Roads, and 25% on Town Roads.
- One of every 13 Wisconsin motor vehicles was involved in an accident in 1962.
- Of male drivers involved in all accidents, 33% were in the 16–25 age group; in fatal accidents 38% were in the 16–25 age group.
- 8,968 Wisconsin citizens were killed in motor vehicle traffic accidents during last 10 years—8,300 Wisconsin soldiers were killed during World War II.
- During 1962 one driver was involved in a traffic accident resulting in death, injury, or property damage of $100.00 or more every 4.4 minutes.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JANUARY 1964
Vol. 63 No. 1

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Chaplet for Charlie

■ EVEN A QUICK look at the literature published by the American Management Association produces a deep impression of the necessity for developing executive talent. Private commercial organizations spend hundreds of thousands of dollars on systematic programs for recruiting or developing managerial capability of an executive calibre. Fortunate indeed is the organization, commercial, philanthropic or professional, that has at its head a chief officer who can fill the role of an executive with skill, devotion, and unquestioned loyalty to the principles of the group.

Fortunate, indeed, is the State Medical Society of Wisconsin with Charles H. Crownhart as its executive officer. In the kind of office that often attracts the well-meaning ineffective who finds himself uncomfortable in the competitive environment of private enterprise, we have a man with the capability to administer a commercial establishment of vast complexity. Among professional organizations, we are outstanding for the vigor of our programs, for the vitality of our growth, and for the community-oriented liveliness of our activity. A large part of whatever praise we receive as an organization is due to Charlie Crownhart's skill as an executive.

For the job of an executive officer of a medical society is not an easy one. Crownhart cannot give orders as would the boss in a private organization. He must persuade and convince. He must exhort and enthuse professional men who would just as soon devote their leisure time to their own families or their personal hobbies. Yet he must solicit member service without sacrificing his own dignity nor that of the society. This calls for a high degree of personal charm and magnetism.

But important as it is, a cordial personality alone does not make a successful executive. The administrator of any organization, and particularly of a professional organization, must have an idea for the direction of the enterprise. He must have a realistic appraisal of what the organization stands for today and where he thinks it ought to be a decade or two in the future. He must have the ability of translating that concept into practical activity and of persuading those responsible for the articulation of policy that his vision is the right one for the group. Without this kind of vision and its implementation, our own society would be a

dispirited, listless group engaged in the meaningless carbon-copy activities of national medical groups. That we are uniquely a *Wisconsin* society is a tribute to Charlie Crownhart's vision and efficiency as dedicated administrator of our society.

Leadership is a lonely function. It's a sobering experience, and one that requires prudence, tact, and sensitivity. No utterance is casual; no action can be whimsical or capricious. The discipline of leadership is a terrible one, and it requires strong character to stand up to the responsibility that comes with the exercise of authority.

Ralph J. Cordiner, chairman of the Board of the General Electric Company, made this pertinent observation about "the Chief Executive:" " . . . he cannot allow himself to become a mere reed, bending before every current of popular opinion. Because of his position of responsibility, he must be willing to stand and be judged on matters of principle—even though this may, on occasion, make him temporarily unpopular with his associates or with the public . . . and he will probably find his satisfactions in other ways —not popularity. Time has a way of winnowing out the trimmers and resting its longer verdict with men who have tried to maintain personal standards of integrity."

When it comes to counting our assets as a professional society, chief among them should stand the name of Mr. Charles H. Crownhart, our secretary. —D.N.G.

Special Service

KEEPING PACE with the steadily increasing attainment of the State Medical Society's "special service" insurance concept has been the nationwide interest in our plan. Eight years of successful operation have converted many skeptics into enthusiastic rooters, and convinced those who expressed initial approbation that their judgment was correct.

But there are present always those who distrust innovation, who slide toward the halter when the mule is kicking—who can be counted upon to proscribe the efforts of a modern day Fulton, Edison, or Bell. Their criticism of the no-fee-schedule approach to meeting medical expense sometimes seems to be based on befogged conception rather than cogent evaluation of possible defects.

It is basic to enlightened discussion that fundamental features and philosophy of this unique insurance device emerge in clear perspective. Mr. Herman L. Toser, illustrious insurance director of Wisconsin Physicians Service, furnished just that kind of exposition to a recent meeting of the North Central Medical Conference held in Minneapolis. His clear and forcible description, in severely abridged form, follows:

"With the almost unbelievable increase in the volume of catastrophic coverage which is being sold, it is somewhat surprising that there should be any great hesitancy in accepting the 'no-fee-schedule' approach to basic coverage. This is simply another way of saying that if the absence of a surgical-medical fee schedule is creating no big problems in the administration of major illness (catastrophic) coverage, neither should its absence in *basic* contracts prove troublesome.

"The contributions of Blue Shield to the advancement of prepaid health care have been substantial. Best remembered among them, at least as to the general public, is the so-called 'service benefit approach' to the payment of physicians' fees. Its impact on consumer preference becomes more apparent as we compare it with other plans in the voluntary prepayment family.

"The 'indemnity' vehicle, used extensively by the commercial insurance carriers, and by some Blue Shield plans as well, contemplates the payment of specified fees as allowances against physicians' charges. The 'service benefit' concept, on the other hand, provides for the payment of stipulated fees which, under a physician's 'participating agreement,' the physician promises to accept as final compensation for stated forms of surgical-medical services.

"Insurance policies which employ a combination of these approaches are, for the most part, still popularly referred to as 'service contracts.' They contain schedules of fees which participating physicians, by prior commitment, agree to accept in full payment of services rendered to persons within given income brackets. As to those in higher income levels, the stated fees merely represent indemnity allowances.

"The combination of the service and indemnity concepts provides the participating physician with a considerable degree of pro-

tection against static fees in an inflationary economy, while at the same time recognizing the practice of many in the medical profession to charge in keeping with ability to pay. Blue Shield has had no occasion to take a position either in favor of nor in opposition to this practice.

"While many persons, especially in the lower income groups, admittedly still do not enjoy the benefit of health insurance, our national economy has produced a situation in which the numbers of wage earners in the so-called 'full-pay' income levels have become increasingly *smaller* when measured against the total working population. This simply means that the 'full pay' provision of low income ceiling service contracts applies to a measurably smaller percentage of wage earners than in years past; and that with inflationary or other continued increases in income, wage earners have either 'graduated' from one income group to another or have attained income levels beyond those contemplated by *any* of the higher level service benefit contracts available to them.

"These and other facts known for at least a decade to those involved in the purchase of group surgical-medical benefit programs have understandably accounted for increased interest in 'full' service contracts *unrelated to income*.

"While management and labor in industry have not always been in complete agreement on what constitutes 'full coverage' as it applies to the professional services of a physician, it is increasingly clear that as to major items, the objective of the buyer in health insurance bargaining is to purchase *first* but more essentially *last* dollar benefits. This is merely another way of saying that, as to a growing number of industries, the emphasis with respect to surgical-medical benefits has been on reducing if not entirely eliminating the necessity for payment by an employee of that portion of a physician's charges for which an insurance benefit is *not provided*.

"With this historical background in mind, the State Medical Society of Wisconsin set about in 1955 to study the possibility of introducing through its insurance division, Wisconsin Physicians Service, a mechanism which would undertake to pay physicians' charges on other than a schedule basis. It is recognized at the same time the need for a practical substitute for the usual fee schedule—one which would be fair to all concerned, the vendor of services included, with elements of 'control' designed to keep the cost of such broader benefits at a level which would make their purchase financially attractive.

"In its administration of the special service plan, Wisconsin Physicians Service places common-sense interpretations upon the terms 'customary,' 'usual' and 'reasonable.' To understand why this is so requires a thorough appreciation of the manner in which claims arising under the special service contract are reviewed.

"There are in Wisconsin at this time 25 county advisory committees. Some serve a single county and others a number of counties, depending largely on the number of doctors practicing in the area. The county (or counties) advisory committee is appointed by the president of the respective county or regional society to work in the determination of what is customary, usual, and reasonable in the way of physicians' charges. A manual, GUIDE TO COUNTY ADVISORY COMMITTEES, is made available to each member. Members of the WPS claims department attend meetings of the committees but have no voice in the final determination of fee ranges or allied matters.

"When such a committee first begins to function, considerable time is necessarily devoted to the establishment of 'ranges' for those surgical-medical services whose need arises with greatest frequency—tonsillectomies, adenoidectomies, appendectomies, cholecystectomies, etc. These ranges in fees apply only to the medical community in question. They may or may not be the same as those of other medical communities.

"As these 'ranges' are determined, the claims department of Wisconsin Physicians Service processes individual claims in keeping with them. When a 'range' has not been established for a specified procedure, the advice of the appropriate county advisory committee is sought at the next regular meeting.

"Likewise, when a fee exceeds that within the 'range' established by a county advisory committee, the claims department makes all the pertinent facts known to the committee, and especially so those considerations, including medical complications, which might justify higher than *usual* fees in *unusual* situations.

"Should the county advisory committee desire more facts before passing judgment upon the reasonableness of a physician's charge, the staff proceeds accordingly. Review of a case, more often than not, reveals the inadequacy of the information provided through the original physician's service report.

"Unlike the service contracts in which the 'full pay' provision is binding when applicable only upon participating physicians, the special service contract of WPS involves *no* participation agreement. It simply assumes that every physician who renders professional, medical services to covered patients will be completely happy to accept by way of compensation a fee which is customary, usual, and reasonable.

"The 'no-fee-schedule' approach can be successful only with a high degree of physician support. If there were reason to believe that any substantial numbers of physicians would refuse to abide by the advice of county advisory committees in the matter of what constitutes reasonable fees, the plan would have little chance of succeeding.

"A properly functioning advisory committee cannot lose sight of its dual responsibility . . . one to the medical society sponsoring the program and another to its fellow medical practitioners. It is through this mechanism that the physicians within a medical community can find a sensible, workable solution to the ever-present problem of controlling their own fees. Unless this or some other equally effective device is employed, the question of controls may well be decided *outside* the medical fraternity.

"The special service contract must be looked upon for what it is and was intended to be . . . a policy embodying broader-than-average benefits at a commensurate price . . . (which) has greatest promise of success when there is evidence that *comparative cost* is less of a competitive factor than *comparative benefits.*

"As to scheduled fee contracts, rate increases are normally the result of higher than anticipated benefit utilization and are seldom accompanied by benefit increases. Except as to those subscribers who qualify income-wise for the 'full pay' provision of such contracts, increases in fees for professional surgical-medical services without a corresponding increase in benefits exposes subscribers to greater out-of-pocket medical expenses.

"If, on the other hand, an increase in rates under a '*no*-fee-schedule' contract was due solely to increases in physicians' fees, all subscribers would benefit to the extent that (except as to maternity services) there would be *no* great out-of-pocket medical expense on their part. The obvious difference lies in the fact that under such circumstances benefits are *increased automatically* in the second situation but not in the first.

"It is the conviction of Wisconsin Physicians Service that the 'no-fee-schedule' concept of voluntary, non-profit surgical-medical insurance is entirely practicable, completely workable, and generally more satisfactory to patients and physicians alike than any other form of health insurance benefits with which it is familiar.

"While making no claim that its own favorable experience in this field will be met or exceeded elsewhere, WPS does not see in this concept any dangers not already recognized. On the contrary, it believes most sincerely that the 'no-fee-schedule' principle can safely be applied to other categories of health insurance in much the same manner that it has been employed in other forms of insurance over a period of many years."

—D.N.G.

CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Theme: Current Programs of National Voluntary Health Agencies

Fifth Annual Event—Saturday, Feb. 29, 1964

During Wisconsin Work Week of Health—SMS Building, Madison

Speakers: J. Scott Butterworth, M. D., past president, American Heart Association, New York City; Morris Fishbein, M. D., editor, Medical World News, New York City; William B. Walsh, M. D., president, People to People Health Foundation, Project HOPE, Washington, D. C.; and Herman L. Toser, insurance director, Wisconsin Physicians Service, State Medical Society of Wisconsin, Madison.

the wisconsin medical journal

VOLUME 63/NUMBER 2 FEBRUARY 1964

Factors Influencing Survival in 100 Patients With Thyroid Malignancy

By G. H. BRISTER, M.D., E. C. ALBRIGHT, M.D., W. H. JAESCHKE, M.D. and HALVOR VERMUND, M.D., Madison, Wisconsin

■ THE PURPOSE of this study was to evaluate the various factors influencing survival of patients with thyroid carcinoma. The effect of histologic type, certain clinical features, and the use of roentgen and radioiodine therapy were examined. The records of all patients with thyroid carcinoma seen at the University of Wisconsin Hospitals during the 20-year period from January, 1937, through December, 1956, were reviewed. Of 126 records available, 100 were included in this study. The remainder were excluded because histologic confirmation was lacking, or on review the carcinoma was found to be metastatic from another organ, or the tissue was unavailable for review. In the 100 patients selected for this study the histologic diagnosis was confirmed by review of the original sections. No patient was lost to follow-up.

Histology. The tumors were grouped following the classification of Warren and Meissner[1] (Table 1). Differentiated tumors were found in 56 patients and were classified as purely or predominantly follicular in 39 and as papillary adenocarcinoma in 17 patients.

Undifferentiated tumors were encountered in 35 patients and classified as giant cell in 11, small cell in 16, and undesignated anaplastic carcinoma in 8 patients.

A miscellaneous group of nine patients included three with Hurthle cell, three with squamous cell carcinoma, and three with sarcomas (one fibrosarcoma and two reticulum cell sarcomas).

Clinical Aspects. *Stage:* The patients were separated into three clinical stages based on the extent of the tumor:

Stage I—The tumor was confined to the parenchyma of the thyroid gland: 26 patients.

Stage II—The tumor had spread beyond the capsule of the thyroid with or without cervical node metastases but without demonstrable distant metastases: 40 patients.

Stage III—Distant metastases were detectable: 34 patients.

The differentiated carcinomas tended generally to be less advanced than the undifferentiated tumors at the time when the diag-

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Presented in part before the Annual Meeting of the Wisconsin Radiological Society, September, 1962, Bailey's Harbor.

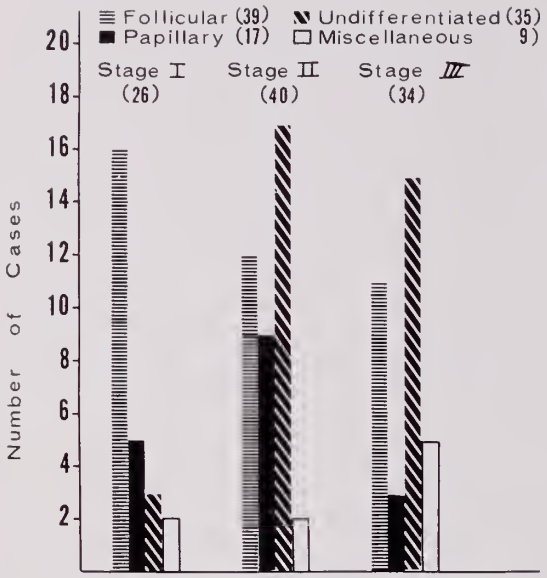

Fig. 1—Incidence of different histalagical types af malignant thyroid tumors in various clinical stages.

nosis was first made. Thus, 21 of the 56 patients with differentiated tumors were classified as Stage I as compared to only 3 of the 35 in the undifferentiated group (Fig. 1). Among the patients with papillary tumors, the greatest number were found to belong to Stage II which might reflect the tendency of this tumor to spread to the regional lymph nodes.

The undifferentiated carcinomas were much more malignant as illustrated by the relatively high proportion of patients in Stage II and III (Fig. 1).

Age: The average age for the entire group at the time of diagnosis was 52 years (range 8 to 80 years). The differentiated tumors occurred more frequently in younger patients. The average age of patients with follicular carcinomas was 46.5 years and with papillary carcinomas 45.1 years, while patients with undifferentiated carcinomas averaged 12 to 13 years older (Fig. 2). No significant differences were found between the sexes in regard to age at diagnosis. There was a greater preponderance of advanced cases among the older age groups (Fig. 3).

Sex: There were 72 females and 28 males, giving a sex ratio of 2.5 to 1 (Table 1). A marked sex difference was found in the distribution of the histological tumor types. Follicular or papillary carcinomas were more frequent in women (46 of 72, or 64%) compared with men (10 of 28, or 36%). Undifferentiated carcinomas occurred more frequently in males (14 of 28, or 50%) compared with females (21 of 72, or 29%).

Symptoms and signs: A mass or nodule in the thyroid was a common finding, being observed in 86 patients (Table 2). There were 41 patients who had had a goiter for more than 5 years, and 23 for more than 10 years.

Pressure symptoms consisting of dysphagia, voice changes or dyspnea were present in 46 patients and were most frequently observed in patients with undifferentiated tumors. Thus, 10 of the 11 patients with giant cell carcinoma and 11 of the 16 patients with small cell carcinoma complained of such symptoms. Local pain in the thyroid region was less common, however, and was reported by only 15 patients. Symptoms secondary to metastases were present in 25 patients on admission, and 13 of these had undifferentiated tumors. Hyperthyroidism was diagnosed clinically in 9 patients, but verified by increased I^{131} uptake or basal metabolic rate in only 4. Four patients had a history of having had thyroid surgery for toxic goiter from 4 to 35 years before the diagnosis of malignant thyroid tumor was made.

Methods of Therapy. *Surgery:* In the operable cases (Stage I and II) treatment consisted of thyroidectomy. Most patients (52) had subtotal thyroidectomy. Total thyroidectomy was performed in 7 patients. Radical neck dissection was carried out in 8 patients, all with Stage II tumors.

It is the present policy at the University of Wisconsin Hospitals to perform neck dissections when metastatic nodes are found and the primary tumor can be removed. Total thyroidectomy is performed only in cases with involvement of both lobes or if radioiodine therapy is contemplated.

Roentgen therapy: Roentgen therapy was administered to 48 patients with the aim of

TABLE 1—*Histological Distribution by Sex of 100 Malignant Tumors of Thyroid*

Tumor	Female	Male	Total
Differentiated			
Follicular	30	9	39
Papillary	16	1	17
Undifferentiated	21	14	35
Miscellaneous	5	4	9
Total	72	28	100

eradicating residual tumor after surgery. Since most of these patients were treated before supervoltage radiotherapy was available, the dosages were low according to present standards, varying between 1,200 and 5,880 r in air in daily increments of 200 r in air. Palliative x-ray therapy was administered to 12 patients with Stage III lesions.

The present policy is as follows: Stage I well-differentiated tumors are usually treated satisfactorily with surgical resection alone.

In Stage II tumors and all undifferentiated or locally inoperable tumors, supervoltage radiotherapy is recommended, and supplemented in selected cases by interstitial radium needle implants.

In Stage III tumors, external radiotherapy is used as palliative therapy for relief of pain and is frequently followed by reduction of tumor masses, and occasionally by calcification of osteolytic lesions.

Radioiodine therapy: Radioactive iodine (I^{131}) was administered to 21 patients. The present procedure is to administer 10 units of thyroid stimulating hormone intramuscularly daily for two days followed by a 1 mc. tracer dose of I^{131} to patients with Stage II or III thyroid cancer 5 to 7 days after the operation. If the neck and other parts of the body are shown by scintiscanning to be free of I^{131} uptake by thyroid tissue and the 48-hour urinary excretion of I^{131} is more than 70 per cent, no further I^{131} is given. However, if there is significant uptake in either the thyroid and the adjacent lymph nodes or over areas which may be the site of distant metastases and there is more than 30 per cent retention of the radioisotope in the body after 48 hours, the patient is a candidate for I^{131} therapy. Ten units of thyroid stimulating hormone are given intramuscularly daily on 2 successive days and followed by 50 to 100 mc. of I^{131} orally. This procedure is repeated at 6 to 8 week intervals until no further uptake can be demonstrated by scintiscanning and urinary excretion studies. The patients are maintained in a euthyroid state by administration of 100 to 125 μg. of triiodothyronine daily. The hormone is stopped three to four days prior to therapy in order to facilitate the uptake of I^{131} by residual functioning thyroid tissue.

Survival in Relation to Histology and Clinical Stage. Both the histological tumor type and the clinical stage of the disease were found to have a great influence on the length of survival of the patients (Tables 3, 4, 5) (Fig. 4).

Differentiated tumors: The favorable prognosis in Stage I tumors was illustrated by 16 of 21 patients surviving 5 years, and 12 of 17 patients surviving 10 years, and a minimal average survival time of 133 months.

In Stage II tumors the less favorable prognosis was demonstrated by 12 of 21 patients

Fig. 2—Age distribution of different histological types of malignant thyroid tumors.

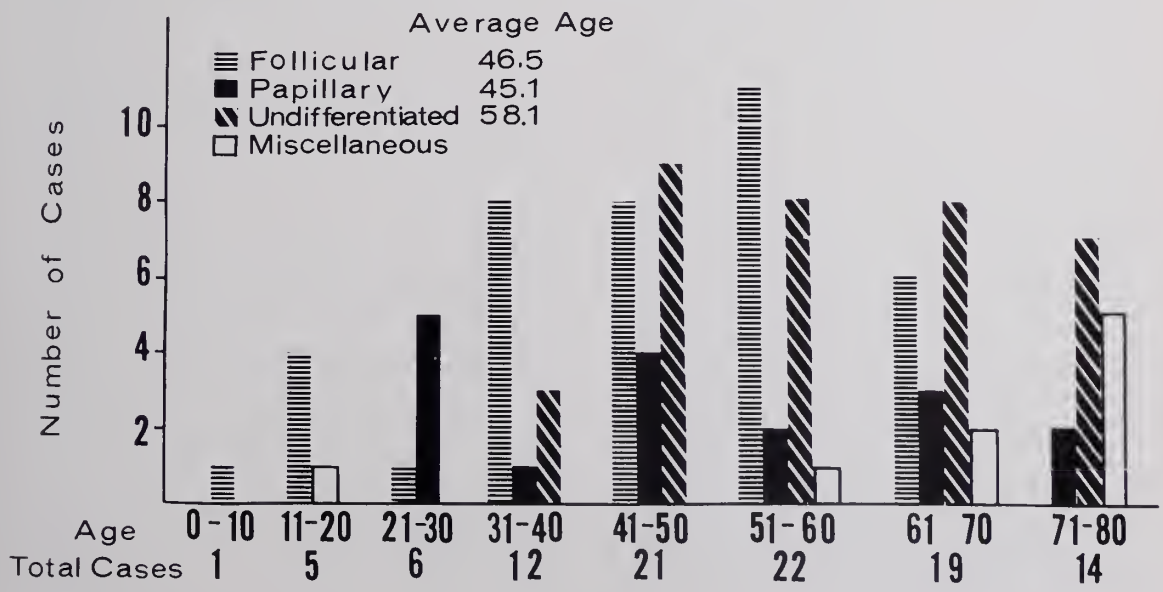

TABLE 2—*Symptoms Present at Time of Diagnosis in 100 Patients With Malignant Tumors of Thyroid*

Tumor Histological type	Number of Patients With:					
	Goiter 5 years or more	Recent new growth	Pressure symptoms	Local pain	Hyperthyroidism	Distant metastases
Follicular	18	15	10	6	5	9
Papillary	5	8	7	1	1	2
Undifferentiated	15	17	23	6	2	13
Miscellaneous	3	5	6	2	1	1
Total	41	45	46	15	9	25

TABLE 3—*Malignant Tumors of Thyroid: Five-year Survival by Histology and Stage of 100 Patients*

Histology	Stage I	Stage II	Stage III	Total
Differentiated				
Follicular	12/16*	6/12	1/11	19/39
Papillary	4/5	6/9	0/3	10/17
Total differentiated	16/21	12/21	1/14	29/56 = 52%
Undifferentiated				
Giant Cell		0/3	1/8	1/11
Small Cell	0/1	0/10	0/5	0/16
Anaplastic	0/2	1/4	0/2	1/8
Total undifferentiated	0/3	1/17	1/15	2/35 = 6%
Miscellaneous				
Hurthle Cell	2/2		0/1	2/3
Squamous Cell		0/1	0/2	0/3
Sarcoma		0/1	0/2	0/3
Total miscellaneous	2/2	0/2	0/5	2/9 = 22%
Total	18/26 = 69%	13/40 = 33%	2/34 = 6%	33/100 = 33%

*Ratio of number of patients surviving to number of patients diagnosed.

alive after 5 years, and 3 of 11 patients alive after 10 years, and a minimal average survival time of 62 months. The outlook seemed somewhat better for patients who had the papillary than for those with the follicular type, but the numbers were small and it is doubtful that much significance can be attributed to this difference.

The prognosis remained grave in Stage III tumors even though a single patient had a remarkably long survival time in spite of extensive metastases.

A 34-year-old woman was admitted to the hospital in 1939. She had a history of thyroid enlargement from 1918, at the age of 13. Subtotal thyroidectomy had been performed at another hospital at the age of 29. A few months after the operation, a tumor involving the left upper humerus was excised elsewhere, but the tissue was not examined histologically. Her main complaint on admission was pain in the left hip. Radiographic examination revealed widespread metastases to the bones with osteolytic lesions in the pelvis, left femur, left humerus, right scapula, and several ribs and nodular masses in the anterior mediastinum. A lesion in the left sixth rib was biopsied and a histological section showed follicular adenocarcinoma of the thyroid. Since first examined in 1939, this patient has had 34 subsequent hospital admissions. Roentgen therapy has been administered numerous times to various metastatic sites, each time followed by relief of pain and in some instances partial calcification of the lesions. In 1942, metastases to the dorsal spine were discovered, and in 1950 a laminectomy was performed for compression of the spinal cord after collapse of several dorsal vertebrae. In 1950, I^{131} was administered for the first time. She has since received 27 courses of I^{131} with a total accumulated dose of 1,496 mc. The patient is still alive 24 years after the diagnosis of widespread bone metastases, and although partially disabled, is able to lead a relatively normal life.

The 5-year survival rate in the entire group of 56 patients with differentiated thyroid tumors was 52 per cent (29 of 56), and the 10-year survival rate was 43 per cent (16 of 37).

The minimal average survival of the same group was 82 months, with more than half of the 56 patients still alive.

The prognosis was best in the age group below 30 years with differentiated tumors, with a 5-year survival rate of 100 per cent (12 of 12), gradually declining to 62 per cent (13 of 21) between 31 to 50 years, 23 per cent (5 of 22) between 51 to 70 years, and 0 (0 of 2) above 70 years of age.

Effect of I^{131} therapy: The overall 5-year survival rate was 62 per cent (13 of 21) with I^{131} and 46 per cent (16 of 35) without

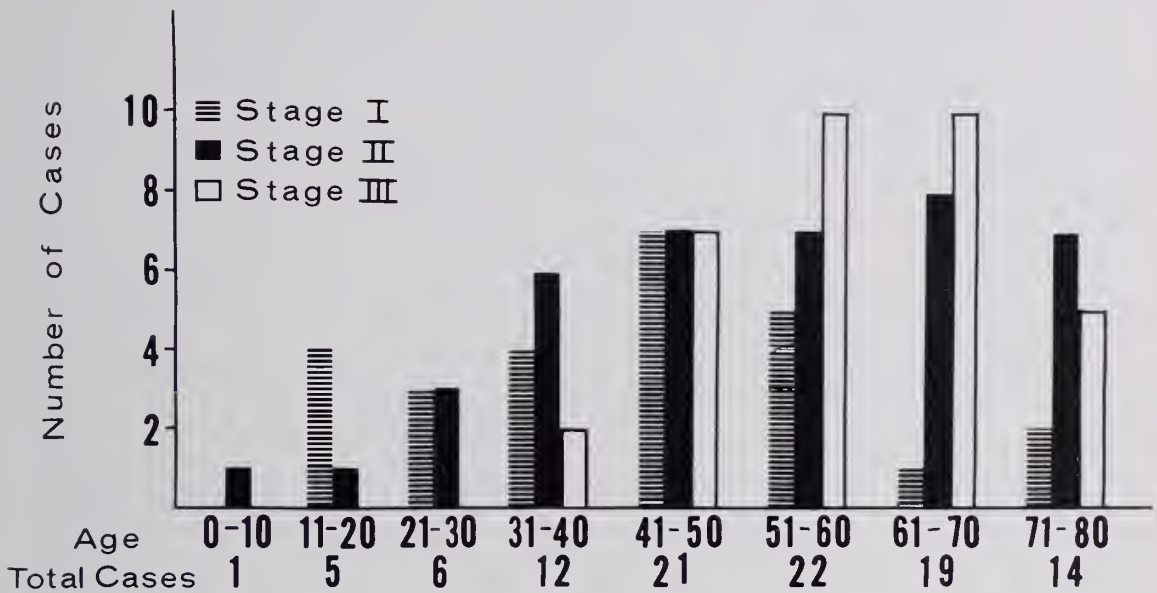

Fig. 3—Age distribution of different clinical stages of malignant thyroid tumors.

the radioiodine. The greatest difference in both the 5-year and the average survivals was found in the patients with Stage II and III follicular carcinomas (Table 7). The significance of the difference is questionable, however, since patient selection may have played a role. The largest accumulated dose of I^{131} was 2,183 mc. administered over 30 months. This patient developed severe bone marrow depression with leukopenia and thrombocytopenia in the presence of actively growing metastatic tumor and died 31 months after the diagnosis was made.

Effect of x-ray therapy: The 5-year and average survival was somewhat better with x-ray therapy in the differentiated tumors, but patient selection could not be excluded (Table 8).

Undifferentiated tumors: In the group of patients with undifferentiated tumors, the prognosis was grave regardless of the stage of the disease or the age of the patient.

Only 3 patients had Stage I tumors and all died within 5 years, with an average survival rate of 46 months.

In Stage II there was only one 5-year survivor among 17 patients. This was a 54-year-old man with an anaplastic spindle cell carcinoma who underwent a subtotal thyroidectomy and a radical neck dissection. He died 80 months later from a stroke without known recurrence.

The average survivals of 3 patients with giant cell carcinoma and of 10 patients with small cell carcinoma were 7 and 8 months respectively. The average survival of the whole group of 17 patients was only 12 months.

The advanced age and the poor general condition of a number of these patients made therapy difficult.

Only one patient with a Stage III undifferentiated carcinoma survived 5 years.

A 42-year-old woman had a 4-month history of swelling in the region of the jugular notch, dysphagia, hoarseness, facial edema due to superior vena cava obstruction and a 20-lb. weight loss. A chest x-ray film showed a large mediastinal mass. She underwent a thoracotomy, but resection was impossible. A biopsy was taken and showed giant cell thyroid carcinoma. She was given orthovoltage x-ray therapy with a dose of 2,000 r in air in 10 days to the mediastinal and cervical areas in August 1952. This was repeated 7 months later with a dose of 1,600 r in air delivered over 8 days. A third course was given in 1956, about 4 years after the first x-ray therapy, delivering 2,400 r in air in 12 days. The patient obtained excellent relief of symptoms and remained relatively asymptomatic for 7 years, until she finally died, 90 months after the initial therapy, of cancer. No autopsy was performed.

Miscellaneous tumors: In the miscellaneous group there were 3 patients with Hürthle cell carcinoma. Two of these had Stage I tumors treated with subtotal resection. One had postoperative x-ray therapy and is well 25 years later. The other had surgery alone and is well 6 years after the operation. The

TABLE 4—*Malignant Tumors of Thyroid: Ten-year Survival by Histology and Stage*

Histology	Stage I	Stage II	Stage III	Total
Differentiated				
Follicular	9/12*	2/6	1/7	12/25 = 48%
Papillary	3/5	1/5	0/2	4/12 = 33%
Total differentiated	12/17	3/11	1/9	16/37 = 43%
Undifferentiated	0/2	0/10	0/9	0/21 = 0%
Miscellaneous	1/1	0/5	0/1	1/7
Total	13/20	3/26	1/19	17/65 = 26%
Percentage	65%	12%	5%	

*Ratio of number of patients surviving to number of patients diagnosed.

TABLE 5—*Malignant Tumors of Thyroid: Average Survival by Histology and Stage*

Histology	Stage I		Stage II		Stage III		Total	
Differentiated								
Follicular	136+*	(16)**	53+	(12)	44+	(11)	85+	(39)
Papillary	121+	(5)	74+	(9)	4	(3)	75+	(17)
Total differentiated	133+	(21)	62+	(21)	36+	(14)	82+	(56)
Undifferentiated								
Giant Cell			7	(3)	13	(8)	11	(11)
Small Cell	50	(1)	8	(10)	8	(5)	11	(16)
Anaplastic	44	(2)	23	(14)	0	(2)	23	(8)
Total undifferentiated	46	(3)	12	(17)	9	(15)	14	(35)
Miscellaneous								
Hurtble Cell	186+	(2)			32	(1)	135+	(3)
Squamous Cell			7	(1)	1	(2)	3	(3)
Sarcoma			2	(1)	0	(2)	1	(3)
Total miscellaneous	186+	(2)	4	(2)	7	(5)	46+	(9)
Total	127+	(26)	38+	(40)	20+	(34)	55+	(100)

*Average survival in months at time of writing; will increase as long as any patient is still alive.
**Total number of patients.

third patient, a 72-year-old woman, had bone metastases and was treated with radioactive iodine and x-ray therapy. She died from cancer 32 months later. Three cases of squamous cell carcinoma and 3 patients with advanced sarcomas died a short time after admission.

Summary of survival data: Among the patients with tumors still confined to the parenchyma of the thyroid (Stage I), the 5-year survival rate was close to 70 per cent (18 of 26). Among 20 patients in this category treated before 1953, there were 13 who survived the 10-year period (65%). The present minimal average survival of the whole group of 26 patients is 127 months, with 18 patients still alive.

In patients with extension of tumor beyond the thyroid capsule but without distant metastases (Stage II), the 5-year survival rate was 33 per cent (13 of 40). The 10-year survival rate was 12 per cent (3 of 26), and the present minimal average survival in the group of 40 patients is 38 months with 13 patients still alive.

In the patients with demonstrable distant metastases (Stage III), 2 of 34 patients were alive after 5 years and one of 19 patients after 10 years. The average survival of the whole group of 34 patients was 20 months.

In the total group of 100 patients, 33 survived 5 years and in the group of 65 patients treated before 1953, 17 were alive for 10 years (26%). A minimal average survival of 55 months for the 100 patients is presently recorded.

Discussion. *Incidence:* The annual incidence of primary carcinoma of the thyroid in the United States has been reported as 1.2 for every 100,000 white males and 3.4 for every 100,000 white females,[2] or approximately one per cent of all malignant tumors.[3] During the 20 years covered by this study, from 20 to 32 persons yearly had malignancy of the thyroid recorded as the primary cause of death in the state of Wisconsin,[4] which shows a death rate close to the 0.6 for every 100,000 reported as the national average.[5] The 100 cases included in this study probably represent about 10

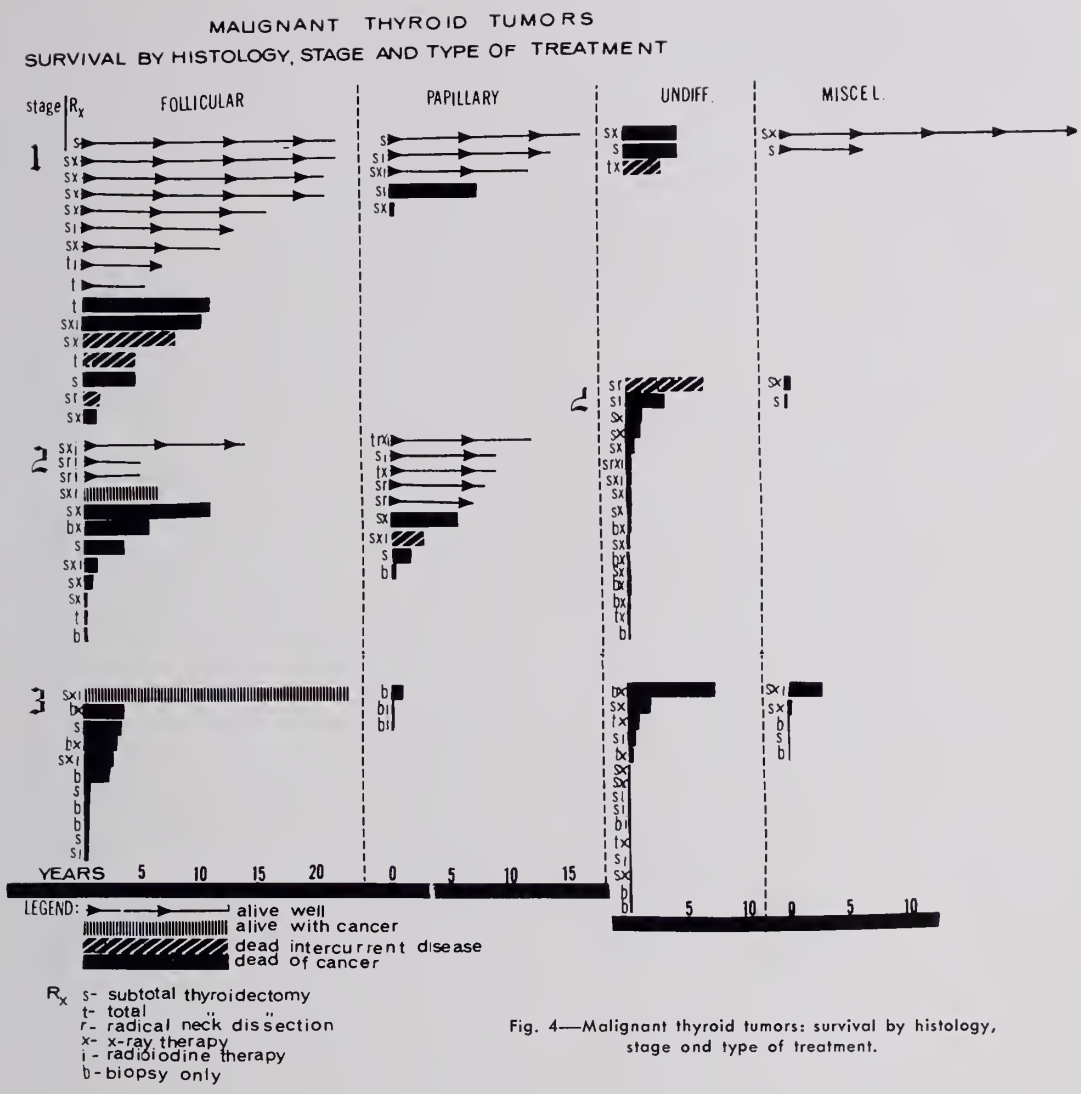

Fig. 4—Malignant thyroid tumors: survival by histology, stage and type of treatment.

per cent of the total number of cases occurring in Wisconsin during this period, but unfortunately cannot be considered a representative sampling because of the unusually large number of undifferentiated and advanced cases.

Ordinarily the papillary carcinomas constitute from 50 to 60 per cent and the undifferentiated varieties from 15 to 20 per cent of all thyroid malignancies.[6] In the present series the papillary carcinomas accounted for only 17 per cent and the undifferentiated carcinomas, 35 per cent, suggesting a certain degree of prehospital admission screening by the referring physicians.

Relationship to pre-existing goiter: The number of patients with pre-existing goiter was unusually high in this series (41%) as compared with the 15 per cent reported by Windeyer[7] and the 25 per cent cited as the usual average.[8] Sloan[9] found that more than 70 per cent of thyroid cancers occurred in glands which appeared otherwise normal.

Recent reports indicate that there is no relationship between endemic goiter and thyroid malignancies. Mustacchi and Cutler[2] showed that the incidence of thyroid malignancy in women living in endemic goiter areas in the northern United States was the same as in women living in nonendemic

areas in the southern states. Furthermore, there has been no decline in the death rate from thyroid cancer since the introduction of iodized salt in 1924 despite the decrease in the incidence of endemic goiter.[10] In Switzerland, however, a reduction in the incidence of both endemic goiter and thyroid malignancies was found,[11] but since 20 per cent of all malignant goiters in that country have been reported as sarcomas,[12] and sarcomas of the thyroid are uncommon elsewhere, this variation in histology might account for the difference in the findings.

The high incidence of pre-existing goiter in the present series may reflect prevalence of endemic goiter among the population of Wisconsin. It is also possible that a solitary nodule may have been misinterpreted as a goiter instead of being recognized as a slow-growing tumor. The incidence of malignancy in solitary thyroid nodules has been reported from as high as 24 per cent[13] to as low as one per cent. [14, 59] Autopsy data[15, 16] and calculations based on the incidence of solitary nodules in the general population[17, 18] tend to support the lower figures.

As more of the thyroid nodules are removed there will be an increasing number of patients subjected to surgery for benign lesions, but a larger number of patients with cancer will survive because the tumor was removed while still confined to the parenchyma of the gland.[19] It is a safe procedure, therefore, to consider a nodule in an otherwise normal gland malignant until proven otherwise by histological examination.[20, 21]

The clinical course: The statistics given in the present series for the 5 to 10 year survival and the average survival rates are comparable to those reported by others for similar time periods.[7, 13, 22-25] Few malignant tumors are so unpredictable as to clinical behavior as some of the differentiated thyroid carcinomas.[9, 26] The degree of malignancy may be quite variable, and a long duration of symptoms before therapy is instituted may not necessarily imply a poor prognosis. The biological behavior of the differentiated adenocarcinomas is in sharp contrast with that of the undifferentiated tumors which, as a rule, grow rapidly, infiltrate extensively outside the capsule of the gland, and are therefore usually inoperable.[27] They also have a great propensity for hematogenous dissemination and since they are not amenable to treatment with either radioiodine, hormones or chemotherapy, and usually are relatively radioresistant, they carry a very poor prognosis.[28]

In addition to the histological tumor type, the anatomic extent or clinical stage of the tumor, the age of the patient, and the type of treatment applied are also important factors influencing the prognosis.

Treatment: The surgical exploration of the thyroid gland, which is necessary to establish the histological diagnosis, should be followed by the thyroidectomy and, if indicated, a radical neck dissection as soon as the diagnosis is established. The opinions differ on how extensive the surgery should be. Some surgeons advocate total thyroidectomy in all cases and for papillary carcinoma radical neck dissection on the side of the lesion.[29-31] Others have reported good results using less radical procedures.[32-34] The recommendations for radical neck dissection were supported by Frazell and Foote[26] who found 85 per cent of 182 specimens removed by radical neck dissection in papillary carcinoma to be positive for lymph node metastases. In cases without clinically palpable lymph nodes, 61 per cent were positive. Support for total thyroidectomy was given by Clark and associates[35] who found by whole organ sectioning technique that 87 per cent of 50 specimens removed by total thyroidectomy showed spread of the carcinoma beyond the primary focus. Crile[36] has recommended radical neck dissection in papillary carcinomas only in selected cases which have developed recurrence after previous inadequate operations. He emphasized the initial resection of the primary tumor and its central metastases. Since 80 per cent of these tumors occur in women below the age of 30, he recommended avoiding deforming operations because the results with more conservative operations have been as good or better.[37]

Radiotherapy: In general, radiotherapy can be administered through an external beam, interstitially through the insertion of radium needles, or systemically through the oral administration of radioactive iodine (I^{131}).

The external radiotherapy may be given with x-rays of different energy or gamma rays from radioactive cobalt or cesium, and is generally reserved for cases falling into one or more of the following groups:

1. In patients found inoperable because of local extension of the primary tumor or

TABLE 6—*Malignant Tumors of Thyroid: Five-year Survival by Age at Diagnosis of 100 Patients*

Tumor	Less than 30	31–50	51–70	More than 70	Total
Differentiated					
Follicular	6/6*	9/16	4/17		19/39
Papillary	5/5	4/5	1/5	0/2	10/17
Total differentiated	11/11 = 100%	13/21 = 62%	5/22 = 23%	0/2 = 0	29/56 = 52%
Undifferentiated					
Giant Cell		1/4	0/4	0/4	1/11
Small Cell		0/5	0/8	0/3	0/16
Anaplastic		0/3	1/4	0/1	1/8
Total undifferentiated		1/12	1/16	0/7	2/35
Miscellaneous					
Hurthle Cell	1/1		1/1	0/1	2/3
Squamous Cell			0/1	0/2	0/3
Sarcoma			0/1	0/2	0/3
Total miscellaneous	1/1		1/3	0/5	2/9
Total	12/12 = 100%	14/33 = 42%	7/41 = 17%	0/14 = 0	33/100

*Ratio of number of patients surviving to number of patients diagnosed.

because of poor general health of the patient.

2. In patients with incomplete surgical excision because of tumor infiltration beyond the capsule and adherence to vital structures.
3. In patients with distant metastases demonstrating inadequate uptake of I^{131}.

Since most thyroid cancers are relatively radioresistant, local sterilization with radiotherapy cannot as a rule be expected, with less than 4,500 to 6,000 r delivered over 5 to 6 weeks to the tumor.[23, 38] In some patients, residual tumor nodules have to be given additional radiation through the implantation of either radium or cobalt[60] needles. Most of the patients in the present series received doses of radiation well below what is recommended today. It is difficult to give more than 4,000 r with conventional x-ray therapy in the 200 to 250 kilovolt range. Higher energy radiation in the range of one million volt or above is now preferred. Meticulous attention to technical details is necessary to insure optimal distribution of the radiation throughout the involved tissue. Radiosensitive structures such as the spinal cord must be protected and the techniques of beam direction must be closely supervised and checked by plotting of isodose curves.

The papillary adenocarcinomas usually respond better to radiation than the follicular types. The giant cell carcinomas are usually quite radioresistant, and 5 or 10 year survivals are exceptional.[23] The small cell carcinomas may be somewhat more radiosensitive. Hare and associates[23] reported 6 out of 30 patients alive for 5 years. Some type of anaplastic carcinomas are apparently more amenable to intensive radiotherapy. Thus Windeyer[7] had a 28 per cent 5-year survival rate in a group of 28 patients with anaplastic tumors without generalized metastases. Smedal and Meissner[39] found 10 out of 44 patients with undifferentiated tumors alive 5 years after external 2 million volt x-ray therapy.

Carefully controlled clinical trials to evaluate the role of external high energy radiotherapy in the treatment of thyroid malignant tumors have not been published, however, so valid statistical data to support the routine use of postoperative radiotherapy are not yet available.

Radioiodine (I^{131}): Theoretically from 60 to 80 per cent of all thyroid cancer patients are potential candidates for I^{131} therapy. Experimentally, Fitzgerald and Foote[40] found

TABLE 7—*Survival Related to I^{131} Therapy: Differentiated Tumors*

Tumor	With I^{131}		Without I^{131}	
	5-year Survival	Average Survival	5-year Survival	Average Survival
Follicular				
Stage I	3/3*	125+	9/13	139+
II	4/5	76+	2/7	36+
III	1/5	72+	0/6	20
Total	8/13 = 62%	86+	11/26 = 42%	84+
Papillary				
Stage I	3/3	135+	1/2	100+
II	2/3	95+	4/6	63+
III	0/2	2	0/1	10
Total	5/8 = 63%	87+	5/9 = 56%	75+
Summary	13/21 = 62%	86+	16/35 = 46%	79+

*Ratio of number of patients surviving to number of patients diagnosed.

TABLE 8—*Survival Related to Roentgen Therapy*

Tumor	With X-ray		Without X-ray	
	5-year Survival	Average Survival	5-year Survival	Average Survival
Differentiated				
Stage I	8/10*	150+	9/11	117+
II	7/11	68+	5/10	56+
III	1/4	96+	0/10	11
Total	16/25	105+	14/31	45+
Undifferentiated				
Stage I	0/2	44	0/1	50
II	0/14	6	1/3	40+
III	1/8	16+	0/7	2
Total	1/24	12+	1/11	17+

*Ratio of number of patients surviving to number of patients diagnosed.

that 46 per cent of 100 cases of thyroid carcinoma concentrated radioiodine enough to give positive autoradiograms. They found positive autoradiograms in 75 per cent of the total number of follicular adenocarcinomas but in only 25 per cent of the papillary varieties and in none of the giant cell, spindle cell, or anaplastic tumors. Marinelli and associates[41] found uptake of I^{131} in certain follicular adenocarcinomas, but none in papillary, Hurthle cell, solid, or anaplastic carcinomas.

Actually, in practice, only 10 to 15 per cent of all thyroid carcinomas will retain enough of the radioisotope to warrant therapeutic trials and only about half of these patients will have significant benefits.[42, 43, 57]

By eliminating all normal remaining thyroid (by surgery or I^{131}) metastases from well differentiated thyroid carcinomas may occasionally show increased capacity to collect I^{131}.[3] Removal of the normal thyroid will increase the output of thyroid stimulating hormone by the pituitary and may cause some well differentiated hormone-dependent thyroid carcinomas to accumulate I^{131}.[44] Intramuscular injection of beef thyroid stimulating hormone is used to stimulate the uptake of I^{131} by certain thyroid adenocarcinomas. Similarly, propylthiouracil in doses of 1 to 2 Gm. daily occasionally increases the capacity of the metastases to concentrate I^{131} by increasing the output of endogenous thyroid stimulating hormone.[45]

Complete disappearance of all demonstrable metastases has resulted from I^{131} therapy in some patients.[46, 47] Haynie and associates[48] reported complete clinical regression and reversion of positive roentgenograms to normal in 16 of 30 patients with distant metastases. Eleven of these had metastases to the lungs and 5 to the bones. The mean dose of I^{131} in this group was 366 mc. Benua and associates[46] reported sustained objective remission in 27 per cent (16 of 59 patients) with differentiated thyroid carcinomatous metastases.

The lack of success of I^{131} therapy in some patients may be due to uneven distribution of the radioiodine within the malignant tissues, and since most radiation effects are mediated through beta rays with an effective range of only a couple of millimeters, failure to eradicate the tumor can be readily explained.

If tumor activity persists after a total accumulated dose in excess of 800 mc. the chances of success are poor[48] and the probability of complications from the high dose of radiation increases.[46] The most serious hazards of high doses of I^{131} include bone marrow depression with leukopenia and aplastic anemia,[42] pulmonary fibrosis,[49] radiation cystitis and leukemia.[46, 50, 51] Unpleasant side effects may occur in the form of parotitis,[58] alopecia, aspermia, amenorrhea, nausea and vomiting, diarrhea and xerostomia.[46]

Crile[52] reported transformation of a tumor of low-grade malignancy into one of aggressive anaplastic nature after I^{131} therapy. The causal relationship is doubtful, however, in view of the fact that certain tumors contain anaplastic elements interspersed between the more highly differentiated tumor tissue, and upon recurrence a greater preponderance of anaplastic elements are encountered because of their faster growth and their resistance to I^{131}.[9]

Balme,[53] Thomas,[54] and Crile[55] have observed regression of pulmonary metastases from papillary thyroid cancer after treatment with thyroid hormone. Crile[33] also believes that postoperative administration of thyroid hormone gives protection against recurrences even in operable tumors.

It was one of the original purposes behind this study to attempt to evaluate the effects of I^{131} on the overall results of treatment of malignant tumors of the thyroid. Some increase in the survival of patients with advanced differentiated tumors could be demonstrated with both I^{131} and x-ray therapy given postoperatively. However, patient selection might have played a role. The clinical impression was that in selected cases, both I^{131} and roentgen therapy had been of distinct benefit. Treatment with I^{131} in the undifferentiated tumors was invariably futile.

Summary. An analysis of the histology, the stage and the clinical symptomatology in 100 successive cases of malignant tumors of the thyroid has been reported. The survival data in relation to the histology and the stage at the time of diagnosis, the age and sex of the patients, and the mode of therapy have been computed and discussed, and comparison made with results presented in the literature.

1300 University Avenue (6).

ACKNOWLEDGMENT: Some of the patients in this series were treated under the supervision of E. A. Pohle, M.D., Emeritus Professor of Radiology. The surgery was performed by the referring physicians or by members of the staff of the Department of Surgery.

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FOR YOUR INFORMATION . . . from the Wisconsin State Board of Health

HOSPITAL PLUMBING HAZARDS

Escaping gas can be detected by smell and most other dangers can be discerned by the human senses. But there is no quick positive way of detecting contamination resulting from sudden hydraulic or pneumatic changes within a plumbing system. Back-siphonage, back-flow or back-pressures may change the course of water or wastes, moving them through existing cross-connections and so affect the efficiency of the very equipment the surgeon or other medical personnel are depending upon to save or safeguard a human life.

The complicated plumbing and piping systems of hospitals, with their numerous special water fixtures, present many opportunities for bacteria-safe water to become contaminated. Possible contamination of drinking, washing, and sterile water warrants serious attention of all concerned with the operation of hospitals and nursing homes.

Board of Health inspectors in visits to hospitals have compiled case histories in which the following unsanitary conditions were found:

1. Aspirators without adequate water protective devices, or aspirators with protective devices improperly installed. As an example, colonic irrigation appliances without safety devices or water protective devices, of a design and so installed that they are subject to back pressures greater than the required pressure to elevate water to and in the safety device.

2. Instrument sterilizers with direct water connections or inadequate air-gap dimensions.

3. Drain connections from sterilizers broken at an improper location resulting in contamination of the unit as well as the implements or instruments within.

4. Water stills with direct or improper air-gap drainage connections so that, as the water cools, the lowering of pressure within can and has drawn outside contamination into the unit.

5. Drinking fountains so designed that the potable water in the distribution system can be contaminated under reduced pressure or an inert condition; and designed so that in drawing water in a container for a patient or other use, the flow of water flushes or comes in contact with the drip pan, waste pipe, or fountain basin.

6. Instrument sterilizers, or all sterilizers for use in these institutions, with waste connections to the drainage system, subject to clogging of the drains which could allow polluted water to back up into the unit and contaminate the sterile material. These devices should be equipped with a definite adequate air-gap connection on their discharge. There should be omitted from their design or construction, any and all built-in overflows, square corners, cracks, joints, and crevices.

For the ultimate in safety of the potable water supply, aspirators, colonic irrigation or vaginal irrigation instruments should not be directly connected to the water supply. Even though vacuum breaking devices are used, possible back pressures may be created that can overcome the safety device.

This report has only briefly touched upon a few of the hazards which exist in hospital plumbing. The need for "prevention rather than cure" is apparent. It is imperative that manufacturers design their equipment for hospitals and nursing homes with a constant goal of upgrading standards to the point where plumbing sanitation is on a par with that maintained by the trained personnel responsible for the health and care of patients.—WILLIAM R. KOENIG, *Director*, Division of Plumbing, Wisconsin State Board of Health.

Parathyroid Cyst Presenting as An Enlarging Cervical Nodule

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■ PALPABLE CYSTS of the parathyroid gland present a difficult problem in differential diagnosis.[1] Usually the correct diagnosis is not established until the time of surgical removal.

The purpose of this report is to present the findings in the case of a patient who had a rapidly enlarging parathyroid cyst together with a review of the literature and discussion of the histogenesis of these cysts.

Case Presentation. A 33-year-old woman was first seen three months after a full-term pregnancy. A 2-cm. nodule that moved on swallowing was palpable in the region of the right lower pole of the thyroid gland. It was not painful or tender, and no other cervical masses or thyroid enlargement were evident. Other physical findings were normal. A diagnosis of solitary nodule of the thyroid gland was made. Three weeks later the nodule had enlarged to 3.5 cm. and had become firmer.

Operative Findings. At operation, a 2 cm., thin-walled, ovoid cyst was found posterior to the right lower pole of the thyroid. It was readily dissected and the base firmly attached to the right inferior parathyroid. Both lobes of the thyroid gland were normal in size and consistency. The cyst was completely excised.

Laboratory Studies. Three days postoperatively the blood urea nitrogen was 5.0, serum calcium 10.2, and serum phosphorus 2.4 mg. per 100 ml., and alkaline phosphatase 2.8 King Armstrong units. Six days postoperatively the serum calcium was 10.3, serum phosphorus 2.6 mg. per 100 ml., and alkaline phosphatase 4.9 King Armstrong units.

After three days of preparation on a 135 mg. calcium diet, the urine calcium was 54 and 80 mg. per 24 hours respectively (normal variability less than 100 mg. per 24 hours). These results are compatible with normal parathyroid activity. The low serum phosphorus level, however, suggests the possibility of mild hyperfunction.

Pathologic Findings. The specimen was a collapsed, wrinkled, red-gray cyst 2 cm. in diameter. The cyst wall averaged less than 1 mm. thick and the inner surface was wrinkled and shiny gray. Microscopically the cyst wall was composed of dense, fibrocollagenous tissue. No epithelial lining was present (Fig. 1). A few lymphocytes were present at the periphery of the wall. The wall contained nests of parathyroid cells (Fig. 1). These were predominantly chief cells with a few oxyphil cells. At one point a small nest of acinar structures lined by a low cuboidal epithelium was present (Fig. 2). These structures resembled the vestigial pharyngeal pouch remnants called Kursteiner's canals as described by Gilmour.[2, 3]

Discussion. In 1959 Perdue and Martin[4] reported the case of a patient with a parathyroid cyst and tabulated data for those previously reported. Data from seven additional patients are presented in Table 1.

The present report brings the total number of reported cases to 33. The average age of these patients was 44 years (range 16 to 79 years). Twenty-four of the patients were women and 9 were men. Twenty-two cysts were located on the left and 11 on the right. In 26 instances the cyst was found in relationship to the lower pole of the thyroid, and only 4 were related to the upper pole. The relationship was not stated in 3 instances.

In 29 instances the cysts presented as a palpable cervical mass. In 3 instances the cysts were incidental findings, either at operation for goiter or at autopsy. In one instance the symptoms were not described.

Five patients showed clinical evidence of hyperparathyroidism.[6, 7, 9, 10]

From the Marshfield Clinic Foundation for Medical Research, the Marshfield Clinic, and the Department of Laboratory Medicine, St. Joseph's Hospital, Marshfield.

The authors are indebted to L. L. Schloesser, M.D. for permission to study his patient and C. A. Vedder, M.D., who performed the operation.

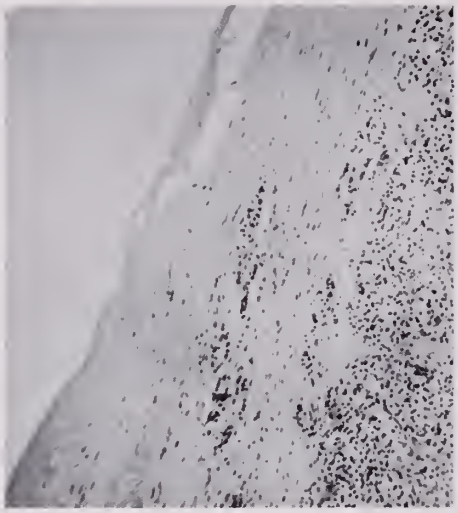

Fig. 1—Shown is the fibrocollagenous cyst wall without epithelial lining and with parathyroid cells within the wall and lateral to it (H & E, X60 magnification).

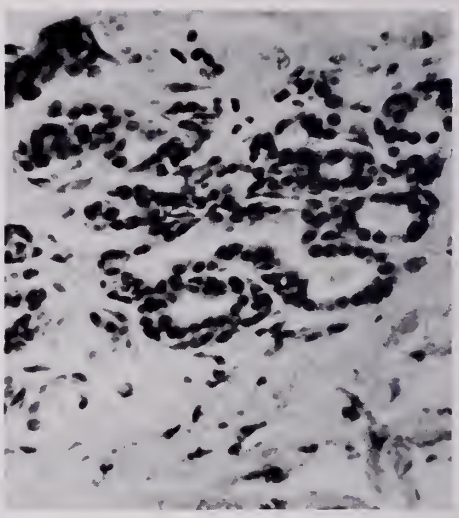

Fig. 2—Acinar structures resembling Kursteiner's canals found at one point in the cyst wall are shown (H & E, X200 magnification).

The diagnosis of these lesions as parathyroid cysts is usually made after surgical removal and histologic examination. In one instance[11] the diagnosis was made preoperatively by the aspiration of oxyphil material from the cyst.

Histogenesis. The origin of cysts in the region of the parathyroid gland is often difficult if not impossible to determine. Evidence of possible etiology usually consists of the location of the cyst, the nature of its lining, and the recognition of parathyroid or occasionally thymic tissues within the cyst wall.

Most of these cysts arise in close proximity to the site of the lower parathyroids (parathyroid III) and occasionally in the region of the upper parathyroid (parathyroid IV), and are thought therefore to be of parathyroid origin. However, other structures; i.e., the thymus and vestigial formations, called Kursteiner's canals, share a common embryonic origin with the parathyroid glands in that they are all derived from the third and fourth pharyngeal pouches.[3] Since thymic tissue and Kursteiner's canals may occur immediately adjacent to the parathyroid gland,[12] it is possible that cysts in the region of the parathyroid may also arise from those structures.

It is curious that most of the cysts recorded were found in the region of the lower parathyroid glands (parathyroid III). Since Kursteiner's canals, when present, almost always are associated with the lower parathyroid,[3] this is circumstantial evidence suggestive of the origin of some cysts at least from these vestigial canals.

The lining of these cysts usually consists of simple cuboidal epithelium or fibrous tissue. A cuboidal epithelium could be provided by either parathyroid tissue or the Kursteiner's canals. It is unlikely that thymic tissue could provide such a lining. In the occasional instance where the epithelial lining is of considerable thickness and shows clearly the morphologic characteristics of parathyroid tissue,[13] there is little doubt that the cysts arise in parathyroid glands.

Cells identified as parathyroid cells frequently are found within the cyst wall. These suggest origin from parathyroid glands; however, this might simply represent incorporation of that tissue during the expansion of the cyst.

It appears that in most instances all that can be assumed for the origin of these cysts is that they originate from derivatives of pharyngeal pouch III and occasionally pharyngeal pouch IV.

Summary. The case of a patient with a parathyroid cyst presenting as an asymptomatic, rapidly enlarging nodule in the region of the thyroid gland has been reported. Thirty-two cases have been reported previously. In 5 cases, evidence of hyperparathyroidism was present. The specific origin of many of these cysts cannot be established conclusively.

TABLE 1—*Summary of Data for Patients With Parathyroid Cysts**

Case No.	Author	Year	Age	Sex	Physical Findings	Operative Findings	Pathology
1**	Keynes and Truscott[5]	1956	40	F	5x4 cm. mass in neck, left inf. pole.	Thin-walled cyst with thin, slightly milky fluid, separate from thyroid.	Flattened epithelium with islands of cells resembling parathyroid tissue in its wall.
2	Arnaud, Walker and Ewer[6]	1960	69	F	1.5x1.5 cm. mass in neck, left sup. pole. Hyperparathyroidism.	Spherical cystic lesion well encapsulated with golden-brown, pasty fluid.	Dense collagenous connective tissue. Focal accumulations of small round cells. No definite parathyroid tissue.
3	Shields and Staley[7]	1960	62	M	3x2.5 cm. mass in neck, left sup. pole. Deepening of voice. Hyperparathyroidism.	Cyst partially embedded in thyroid lobe containing amber fluid.	Fibrous tissue wall containing nests of parathyroid cells.
4	Shields and Staley[7]	1960	57	F	2.5x2.1 cm. mass in neck, right inf. pole. Hyperparathyroidism.	Cyst attached to thyroid gland, containing clear, watery fluid.	Fibrous tissue with an inner lining of cuboidal cells. Nests of parathyroid cells in the fibrous wall.
5	Jonassen[8]	1961	44	F	3 cm. mass in neck, right inf. pole.	Cyst removed separately with thin, translucent clear fluid.	Smooth lining with one small area of thickening, showing parathyroid cells. Thyroid adenoma also present.
6	Malkin and Chapman[1]	1961	77	F	7x5 cm. mass, left sup. pole.	Encapsulated mass with 1 cm. pedicle. Cystic cavity filled with blood and clots.	Collagenous fibrous connective tissue wall with a few areas of epithelial cell clusters. Both parathyroid chief cells and oxyphil cells present.
7	Lohrenz and Neubecker	1962	33	F	2x2 cm. mass in neck, right inf. pole.	Thin-walled ovoid cyst with clear fluid.	Wall of fibrocollagenous tissue with nests of parathyroid cells.

*From literature reviewed since report of Perdue and Martin.[4]
**Case was not listed by Perdue and Martin.[4]

Many probably arise from the parathyroid glands, but the possibility of origin from vestigial epithelial remnants of the third pharyngeal pouch or even heterotopic thymic tissue cannot always be excluded.

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AORTIC RUPTURE

Aortic Rupture After a Minor Fall in a Patient with Extreme Cardiomegaly, ARONSON, WILLARD, Luther Hospital, Eau Claire, Wis. *J.A.M.A.* 186:207–208 (Nov 16) 1963.

This patient, age 64, had aortic insufficiency which was sufficiently well compensated with the aid of digitalis and chlorothiazide that he was able to do strenuous manual labor. He sustained a rupture of the aortic root after a fall from a standing position while pulling on a chain hoist. Rapid death was due to hemopericardium and cardic tamponade.

Doctor Aronson proposed that in this vigorous fall, the unusually heavy heart exerted a severe downward force as a result of its mass and the inertia concomitant with the fall. The aorta ripped at the site of maximum stress, at the point of pericardial reflection and of partial suspension of the heart from the bronchi and mediastinal structures.

The tendency for traumatic aortic rupture to occur in the root and ligamentum arteriosum regions of the aorta where the fixed arch meets the more mobile heart and descending aorta makes it clear that these are points of maximum weakness to stress from various types of trauma. The ruptures have been attributed to different rates of deceleration between the fixed and mobile portions of the aorta. This case where aortic root rupture occurred with relatively minor trauma, but a very large heart serves as a corollary to observations about the mechanical predilection of these points to rupture after falls and blunt trauma.

CASE REPORT

Infectious Mononucleosis and Facial Diplegia

By RALPH GUY BONFIGLIO, M. D. and RALPH L. SUECHTING, M. D.
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■ THERE HAVE BEEN earlier reports in the literature of central nervous system involvement with infectious mononucleosis. The first case was described by Epstein and Dameshek in 1931.[1] In Scandinavian literature Johansen[2] also reported a similar occurrence. The type of neurologic involvement has included isolated incidences of peripheral nerve palsies with normal spinal fluid findings. Serous meningitis, encephalitis, and also the Guillain–Barre type of polyneuritis have been associated with infectious mononucleosis but with abnormal spinal fluid findings. In 1935 Fledelius[3] reported a case of occulomotor paresis and Saksena,[4] a case of serratus anterior paralysis associated with infectious mononucleosis. The spinal fluid in these cases was normal. Richardson[5] reported serratus magnum palsy; Silversides and Richardson[6] mentioned a case of bilateral facial palsy; and Canter and Schillhammer[7] reported a case of bilateral Bell's palsy with infectious mononucleosis. All cases were without spinal fluid studies.

This report presents a case of infectious mononucleosis complicated by bilateral facial palsy with a normal spinal fluid examination.

Case Report. The patient was a 40-year-old housewife. One month before admission to the hospital she developed an upper respiratory infection associated with soreness in her neck, cervical adenopathy, temperature elevation, and fatigability. These symptoms all abated after a few days. She remained asymptomatic for one week and then began to complain of generalized soreness including the muscles of the legs and neck. These symptoms continued for approximately five days after which she noted a bilateral facial weakness.

Her past medical history was noncontributory, and there was no previous history of central nervous system disease.

One week after the onset of facial palsy physical examination revealed a well-developed, well-nourished white woman. Her blood pressure was 120/70, pulse was 84 and regular, and temperature was normal. There was no obvious lymphadenopathy, and the throat appeared normal. The tip of the spleen was palpable at the left costal margin on deep inspiration. The liver was not enlarged. Neurological examination revealed only a bilateral facial paralysis of the peripheral type. The remaining cranial nerves were normal bilaterally.

The complete blood cell count revealed a hemoglobin level of 12.4 Gm.; hematocrit reading of 38.5%; sedimentation rate of 38 mm. per hour by the Westergren method; white blood cell count of 6,750 with a differential count of 58 lymphocytes, many of which were atypical, 5 stab forms, and 37 segmented neutrophils; platelets appeared normal. The urinalysis was negative. Heterophil agglutinations were positive in a dilution of 1:224 after guinea pig absorption and 1:28 after beef absorption. LE cell preparation was negative on two occasions. The cerebrospinal fluid revealed normal pressure and manometrics. No cells were found. The spinal fluid total protein was 36 mg. per 100 ml. The serology was negative. The colloidal gold curve was 0122210000. The chest x-ray film revealed calcified hilar nodes on the left, but no evidence of parenchymal disease. The skull x-ray films were reported negative.

Complete recovery of the bilateral facial palsy occurred in three to four months without treatment.

Conclusion. A case of bilateral facial palsy following infectious mononucleosis with normal cerebrospinal fluid has been presented. We believe that such an association is per-

haps more common than is generally accepted.

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FIGURES RELEASED ON COST OF TB PATIENT CARE

The State Board of Health recently released figures on the cost of caring for tuberculosis patients in the 1962–1963 fiscal year.

During the year, Wisconsin's 14 county and 2 private sanatoria provided 33,641 patient weeks of sanatorium care, and 34,735 outpatient visits at a total cost of $4,486,486. Comparative figures for the 1961–1962 year were 34,961 patient weeks of inpatient care and 32,404 outpatient visits at a total cost of $4,795,563.

Of the amount expended in 1962–1963, the State contribution was $1,116,088; $21.00 per week for sanatorium inpatient care and $3.00 for each outpatient visit.

A small but significant trend toward less sanatorium care and more outpatient care for TB patients is revealed by the figures. Inpatient care declined in the last fiscal year by 3.9 per cent and outpatient visits increased by 7.2 per cent. These figures agree with a nationwide trend toward less inpatient sanatorium care and more emphasis on outpatient care of the tuberculosis patient.

Although the per capita cost of sanatorium care of TB patients in 1962–1963 period averaged $129.25 a week, a decline of $5.52 from the per capita of the previous year, the weekly per capita for individual sanatoria varied considerably from the average cost. The lowest figure reported was $77.32 per week and the highest $226.19 per week.

Following are the weekly per capita costs of providing inpatient sanatorium care for 1962–1963 as compared to 1961–1962 for each of the tuberculosis sanatoria in Wisconsin.

	Weekly Per Capita Costs	
Sanatoria	*1961–1962*	*1962–1963*
Hickory Grove, Brown County	$100.17	$ 96.81
Lake View, Dane County	212.12	226.19
Maple Crest, Manitowoc County	117.83	85.41
Middle River, Douglas County	189.19	174.68
Mount View, Marathon County	122.73	143.39
Mount Washington, Eau Claire County	121.88	113.27
Muirdale, Milwaukee County	196.19	216.83
Oak Forest, La Crosse County	95.10	83.80
Pinehurst, Rock County	114.47	114.58
Pureair, Ashland, Bayfield, and Iron Counties	145.45	142.15
Riverview, Outagamie County	91.86	80.50
Rocky Knoll, Sheboygan County	85.90	77.32
Sunny View, Winnebago and Fond du Lac Counties	116.23	120.02
Willowbrook, Kenosha County	149.29	112.84
Morningside, Madison	140.24	157.11
River Pines, Stevens Point	109.24	123.11

OBSTETRICAL BRIEF

UNEXPECTED MASSIVE HEMORRHAGE

By BEN M. PECKHAM, M. D., Madison, Wisconsin

Deaths from sudden obstetrical hemorrhage are almost uniformly preventable if the emergency occurs in the hospital. Preparations for management can and should be made in advance.

Have you reviewed your maternities' state of preparedness?

I. Hospital Services
   A. Blood Bank
      (1) Type O Rh negative blood on hand
      (2) Personnel available within 15 to 20 minutes
   B. Operating room facilities in the maternity with adequate emergency equipment including:
      (1) 15-gauge needles
      (2) Cut down equipment
   C. Adequate anesthesia
   D. Adequate nursing assistance

II. Professional Staff Preparedness
   A. Trained assistance available—colleague or house staff
   B. Necessary familiarity with equipment and its location
   C. Preconceived plan of action

Recognition of situations which may lead to severe hemorrhage and prophylactic preparations will minimize blood loss, facilitate replacement, reduce confusion, and save lives.

A diagnosis must be made before intelligent and effective therapy aimed at the control of hemorrhage can be instituted. *This requires complete examination.*

Presented at a conference on "Maternal Deaths—What Can We Do About Them?"; St. Catherine's Hospital, Kenosha, Jan. 16, 1963; sponsored by the CES Foundation of the State Medical Society.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: C. E. OBERDORFER, M.D.

Racine, Wisconsin

Case Presentation.* A premature white female infant was born on Oct. 19, 1959. The mother was a 19-year-old Rh positive, Kahn-negative primigravida who entered the hospital because of premature rupture of membranes and subsequent bleeding. The delivery was spontaneous.

The infant's weight at birth was 4 lbs. 11½ oz. The Apgar rating was 5. Physical examination on the day after birth revealed slight jaundice. The head was smaller than normal. The patient was lethargic, listless, did not cry and responded poorly to stimulation. Slight sternal retraction was noted. The lateral aspects of the chest were described as having a "caved-in" appearance. The back had a "hunched-up" shape, especially over the thoracic spine. Respiratory sounds were shallow and harsh. The clinical impression at that time was one of a premature infant with atelectasis, erythroblastosis foetalis to be ruled out.

On October 21, respiratory difficulty was first noted and the infant was placed in an incubator (Isolette). On October 22, fever was present, with the rectal temperature reaching 100.8 F. On October 23, red blotches were noted over the face and upper chest. Hepatomegaly of a minimal degree was first noted on October 27. On this day, the clinical diagnosis of cytomegalic inclusion disease was first suggested on the basis of microcephaly, prematurity, hepatomegaly, jaundice, and a systemic disease picture with central nervous involvement. Throughout the hospital stay, bouts of respiratory difficulty, cyanosis, and fever occurred. Antibiotic therapy included the use of penicillin, erythromycin (Ilotycin) and sulfadiazine. Jaundice of varying intensity persisted until Jan. 29, 1960. The body weight ranged from 4 lb. 4 oz. to 5 lb. 15½ oz., reaching the latter figure on Dec. 26, 1959. On November 12 and 13, the skin was described as appearing slightly edematous. On occasion, excess bleeding was noted from puncture wounds of the heels, which were the sites for obtaining blood specimens. On December 6, abdominal distention was noted and this persisted until December 10. On December 18 white patches, which were diagnosed as thrush, were seen on the tongue. Rigidity of the upper and lower extremities was first noted on November 13. On December 12 convulsive seizures began. Seizures of increasing frequency were noted until Feb. 7, 1960, at which time the infant died. Permission for autopsy was not granted.

Laboratory studies on Oct. 24, 1959, showed the serum chlorides to be 130, carbon dioxide 17.8, sodium 163, and potassium 3.8 mEq./l. The direct Coombs test was negative. The indirect van den Bergh's test was 9.2 mg. per 100 ml. On October 27 the direct van den Bergh's test was 1.8 and the indirect van den Bergh's test, 10.8 mg. per 100 ml. Hanger's (cephalin-cholesterol flocculation) test was 3 + at 24 hours and 4 + at 48 hours. An indirect van den Bergh's test performed on November 4 was 5.5 mg. per 100 ml. On several occasions, bilirubin was present in the urine. A 1+ albuminuria was noted on October 27. The urine was negative for porphobilinogen and cystine crystals. On November 19 1+ albuminuria was again noted and 50 to 60 red blood cells per high-power field were present. The red blood cell count on October 20 was 4,710,000 per cu. mm. and the hematocrit reading was 53%. The total hemoglobin was 16.0 Gm. per 100 ml. with 1.3 Gm. of resistant hemoglobin and 14.7 Gm. of nonresistant hemoglobin. The white blood cell count on this date was 12,770 per cu. mm. The differential count showed 3 bands, 41 polymorphonuclear cells, 43 lymphocytes, 7 monocytes, 3 eosinophils, and 1 basophil. Twenty-one normoblasts and 2 myelocytes were present. The red blood

* From St. Luke's Memorial Hospital. This case was diagnosed clinically by Dr. William Henken and radiologically by Dr. Paul Miller, both of Racine.

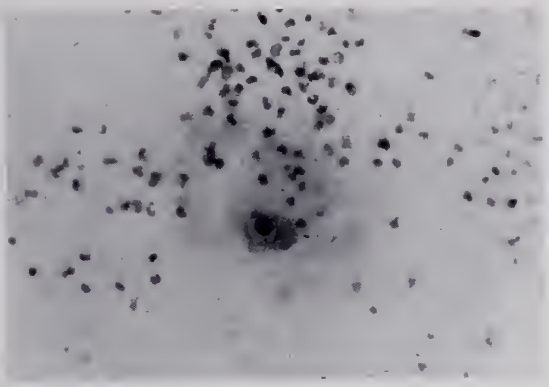

Fig. 1—Microscopic view of intranuclear inclusion body in epithelial cell from urine.

Fig. 2—Lateral view of paraventricular calcification of brain.

cells were macrocytic and normochromic. Occasional spherocytes and target cells were observed. On November 3 the red blood cell count dropped to 3,040,000 per cu. mm. and the hematocrit reading was 30%. The hemoglobin level was 10.2 Gm. per 100 ml. Transfusions with red blood cell mass were given and the hematologic picture returned to normal. On December 7 anemia was again noted with the red blood cell count being 3,080,000 per cu. mm. and the hematocrit reading 29%. The hemoglobin level was 9.2 Gm. per 100 ml. at this time. During the hospital stay, the white blood cell count was as high as 25,000 per cu. mm. with a shift to the left being noted. The leukocytosis was at its height during the episodes of fever. Thrombocytopenia was not present. After several attempts to demonstrate intranuclear inclusion bodies in the urine, success in the identification of such structures was finally obtained after immediate fixation of the specimen (Fig. 1).

X-ray examination of the skull on October 28 showed moderate microcephaly with intracranial calcifications which were symmetrical and paraventricular in location. The differential diagnosis was between toxoplasmosis and cytomegalic inclusion disease, probably the latter because of the distribution of the calcification (Figs. 2, 3, 4). A chest x-ray film on November 6 was considered normal. Repeat skull x-ray studies on Feb. 1, 1960, showed fairly normal growth development of the skull since the last examination. Intracranial calcification persisted. The bones of the vault were poorly calcified and considerably thinner than usual. The sutures were wide and there was some bulging through the anterior fontanel suggesting increased intracranial pressure.

Discussion. Cytomegalic inclusion disease is a viral disease which may be seen at all ages, but which appears to be of little clinical significance outside of infancy. The disease may be transmitted by a pregnant woman, who is asymptomatic, to the fetus. In the newborn, it may be a fatal disorder which clinically simulates erythroblastosis foetalis. Until recently, it was diagnosed almost exclusively by autopsy. However, since 1950 the antemortem diagnosis has been made with increasing frequency. This abnormality was first described by Ribbert[1] in 1881. Wyatt and associates[2] in 1950 were the first to suggest that the diagnosis could be made by detecting the presence of intranuclear inclusion bodies in epithelial cells found in the urine. However, the epithelial cells from almost any part of the body may be involved.

Throughout the years, numerous agents have been considered as the causative factor. According to Lysaught[3] these include bacteria, spirochetes, protozoa, and various toxic materials. Smith[4] in 1956 proved the etiologic agent to be a virus. In 1957, Weller and associates[5] demonstrated antibodies against the virus. The disease closely resembles salivary gland virus disease, seen in such an animal as the monkey, although the two agents are antigenically different.

Clinically, the disease resembles erythroblastosis foetalis. The infant is usually very ill, premature, and is almost always the first-born. The prematurity, in many cases, is based upon weight and length, rather than age. Mild jaundice, hepatomegaly, splenomegaly, and hemorrhagic tendencies are present. Jaundice may first appear up to 14

days after birth. Respiratory difficulty, edema, thrombocytopenia, and hyperbilirubinemia are common findings. Intracranial calcifications, which usually have a paraventricular location, may be present. Microcephaly, hemolytic anemia convulsions and chorioretinitis are other findings. Lysaught[3] includes erythroblastosis, syphilis, acute hemolytic anemia, toxoplasmosis, galactosemia, atresia of the bile ducts, visceral herpes simplex, sepsis, and neonatal hepatitis in the differential diagnosis.

Diagnosis. Although cytomegalic inclusion disease may be suspected clinically and radiologically, laboratory confirmation is paramount. The most reliable diagnostic test is isolation of the virus from the urine. Unfortunately, only a few laboratories are capable of this procedure. Some laboratories have been able to demonstrate specific antibodies of neutralizing and complement fixing type in the blood. Biopsy of the parotid gland, liver, and kidney may be performed in search for inclusion bodies. Biopsy of the parotid gland alone may not be of great diagnostic significance since the virus may be latent in the salivary glands of some individuals. Examination of other organs is, therefore, important to determine if the disease is generalized. Lysaught[3] stresses "touch" preparations of biopsy material. With this technique, a clean slide is touched to the biopsy and stained with hematoxylin and eosin. The use of this method on the placentas of jaundiced bleeding newborn infants is suggested by Lysaught.[3]

In most laboratories, however, the diagnosis rests upon the demonstration of intranuclear inclusion bodies in tubular epithelial cells found in the urinary sediment. The inclusion body in such a cell is usually located in the center of the nucleus and is usually surrounded by a halo. The chromatin is condensed in the form of a ring around the inner surface of the nuclear membrane. Because of the resemblance to the eye of an owl, this cell is commonly referred to as the "owl eye" cell (Fig. 1). Naib[6] is of the opinion that at least three fresh morning specimens should be examined, since the number of positive cells per specimen are usually few in number. He also states that because of the rarity of diagnostic cells in urine sediment, even when the urinary tract is extensively involved, the disease cannot be ruled out on the basis of negative cytology. In cases which are suspected clinically, and in which

Fig. 3—Anteroposterior view of paraventricular calcification of brain.

Fig. 4—Basilar view of paraventricular calcification of brain.

negative cytologic results are obtained, he recommends further study, including viral isolation, tissue biopsy, and cell culture.

Treatment. No specific treatment is known for cytomegalic inclusion disease. Symptomatic treatment includes the use of blood transfusions and antibiotics. Corticosteroids have been used but with varying responses. Margileth[7] reported a patient who survived after being treated with cortisone. Katz and Kibrick,[8] however, are of the opinion that corticosteroids are of little value. Elliott and Elliott[9] believe that the brain damage which the disease causes in the newborn infant may be preventable by the exposure of female children to harmless infection with the virus before their child-bearing age, as so often occurs with rubella.

Prognosis. Although McElfresh and associates[10] reported two patients who survived without treatment, most infants succumb. Both patients studied suffered cerebral damage.[10] Pulmonary hemorrhagic disorders are the usual cause of death during the first several weeks. Neonatal hepatitis and interstitial pneumonitis are common causes of death later in the disease.

Comment. In the case of cytomegalic inclusion disease as presented here, urine was sent to the laboratory on four separate occasions for the detection of inclusion bodies in the unfixed state. Although such specimens were immediately fixed in 95 per cent ethyl alcohol upon being received in the laboratory, the time lapse from when the urine was passed until fixation ranged from one-half hour to several hours. All of these specimens proved negative for inclusion bodies when examined cytologically, after having been stained according to the Papanicolaou technique.

The need for immediate fixation of cytologic specimens is common knowledge to those individuals trained in the field of cytodiagnosis. Because of this, the female infant in this case was carefully observed and as soon as urine was passed into the attached Pediatric Urine Collector, it was immediately fixed in 95 per cent ethyl alcohol. With this technique, inclusion bodies were detected for the first time. Because of the impracticability of such constant surveillance, 10 ml. of alcohol was placed in the attached Pediatric Urine Collector, with resulting immediate fixation of the specimen. Using this procedure, inclusion bodies were detected in three consecutive specimens.

Summary. The literature on cytomegalic inclusion disease has been reviewed and current concepts of the disease have been presented.

A case of cytomegalic inclusion disease, which demonstrated paraventricular calcification of the brain and intranuclear inclusion bodies in the epithelial cells of the urine, has been discussed. The need for immediate fixation of urine in 95 per cent ethyl alcohol for the demonstration of intranuclear inclusion bodies has been stressed. A technique for assuring adequate fixation has been suggested.

Although cytomegalic inclusion disease is relatively rare, it will be diagnosed with increasing frequency if all premature infants with the clinical picture of microcephaly, hepatomegaly, splenomegaly, jaundice, and a systemic disease picture with central nervous system involvement be studied by means of specific laboratory examinations.

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COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine

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Drug Treatment of Migraine Headache

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■ MIGRAINE IS AN ILLNESS which has been described in antiquity. Although the precise etiologic mechanisms still have not been elucidated, the more prominent signs and symptoms of the disease appear to be of vascular origin. An initial constriction of blood vessels supplying the brain and retina may account for some of the visual, sensory and motor prodromata observed in some patients. The ensuing headache appears to be due to dilatation and distension of pain sensitive intracranial and extracranial blood vessels. The vasodilatation is accompanied by edema of the vessel walls and the surrounding tissue. A polypeptide called "neurokinin" which lowers pain threshold is said to accumulate in the blood vessel walls and perivascular tissue.[1] Other endogenous substances such as serotonin, histamine and acetylcholine have also been suggested as possible etiologic agents in the pain of migraine.

The most valuable agents in the symptomatic treatment of acute attacks of migraine headache are the ergot alkaloids. Chemically, the ergot alkaloids are derivatives of lysergic acid and ergotamine is the principal member of this class of drugs used in the treatment of migraine.

The direct smooth muscle stimulant action of ergotamine, particularly on vascular smooth muscle, constitutes the most important action of the drug and the vasoconstriction which it produces is the basis of its efficacy in migraine headache.

Used in proper dosage and in the absence of contraindications, the incidence of toxic side effects of ergotamine is probably quite low. However, the drug is potentially dangerous and one of the most feared complications of therapy is gangrene which appears to be due to vascular endothelial damage as well as vasoconstriction. The more frequent side effects probably include nausea and vomiting, paresthesias, and signs and symptoms of vascular insufficiency: precordial distress, muscle pain and a host of other vascular conditions ranging from thrombophlebitis to acute arterial occlusion. Ergotamine is contraindicated in pregnancy because of its oxytocic action and in hepatic disease because there is an unusual sensitivity to the vascular effects of the drug in this disease. Ergotamine is also contraindicated in coronary disease, peripheral vascular diseases, hypertension, severe renal disease and hyperthyroidism.

Ergotamine is available in combination with caffeine, the latter being a synergist to the ergot alkaloids in the treatment of migraine. Ergotamine preparations containing belladonna alkaloids, analgesics, sedatives and antihistaminic drugs are also available. The superiority of such combinations over ergotamine alone needs verification. Dihydroergotamine, a semisynthetic derivative of ergotamine, is a weaker vasoconstrictor agent and is less toxic. However, in equivalent therapeutic doses (the dose of dihydroergotamine is twice that of ergotamine), there is probably little difference between the two drugs, and in some instances dihydroergotamine has produced more rather than less side effects.

Administered in adequate dosage in the prodromal period or immediately after the onset of the headache, ergotamine can be expected to be effective in approximately 70 per cent of the cases. The importance of early administration is to be emphasized.

Many therapeutic failures are due to delayed administration of the drug. The parenteral route is probably the most effective route but suffers obvious limitations. The most convenient route is the oral one. However, absorption of the drug from the gastrointestinal tract is incomplete and may be slow and variable. The common procedure for oral administration is to give an initial dose of 1 to 2 mg. of ergotamine, repeated as needed at half-hour intervals for a total dose of not more than 6 mg. Some physicians have emphasized the need for establishment of a minimal effective initial dose given prior to or immediately after onset of the headache. This dose must be determined for each patient individually. During a first trial, one tablet (1 mg.) may serve as the initial dose; if this fails, two or rarely three tablets should be taken as an initial dose for subsequent attacks. The drug can also be given rectally and sublingually, particularly in patients who are unable to retain the medication orally. Ergotamine is also administered by oral inhalation. Some reports suggest that this route may be as effective as the parenteral one.

The daily use of ergotamine to prevent attacks of migraine has usually been unsuccessful and it has even been stated that such chronic use may increase the frequency of attacks. More recently, methysergide (Sansert) has been introduced in the prophylactic management of migraine headache. Chemically, methysergide is also a derivative of lysergic acid. The initial clinical studies suggest that daily administration of the drug will successfully prevent or reduce the incidence of headache episodes in many patients.[2,3] The drug, however, is of no value in the management of acute attacks.

The mechanism of action of methysergide has not as yet been elucidated. Experimentally, the drug has been shown to be a potent antagonist of serotonin. However, it is premature to relate this action to the suppressant effect of the agent in migraine since the role of serotonin in migraine is not established. Experimentally, methysergide does not possess any acute vasoconstrictor action when administered parenterally and it is not thought to act by the production of a long lasting vasoconstriction.[2] The drug, however, is reported to potentiate the vasoconstrictor action of catecholamines.[4] Furthermore, toxic side effects of methysergide have included symptoms of vascular insufficiency indicating that the drug does produce vasoconstriction with chronic administration. It has been suggested that "unstable vasomotor centers" may be a factor in the pathophysiology of migraine and that the action of methysergide is related in part to a modulating (depressant) action on the central vasomotor centers.[4]

Methysergide may produce a variety of side effects although in many instances it is difficult to dissociate drug side effects from the systemic manifestations of migraine. Perhaps the more common ones are nausea and vomiting, epigastric pain, symptoms of vascular insufficiency, dizziness and a variety of other central nervous system symptoms. Untoward effects which led to discontinuation of the drug occurred in approximately 20 per cent of the patients in some of the early reports. This percentage may be influenced by the fact that in some studies relatively high doses were employed and it has been recommended that the dosage not exceed 8 mg. per day.[3] The drug should be withdrawn should symptoms of vascular insufficiency such as intermittent claudication, precordial distress, cold, numb and painful hands or feet occur. Because of residual oxytocic and vasoconstrictor properties, methysergide carries essentially the same contraindications as ergotamine.

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THE PRESIDENT'S PAGE . . .

"Welfare State" What Is It?

■ WHO CAN TELL US, or where can we find out, understandably, what "welfare state" means? Who can define it? Where can definitions of this term be found? What is the role of organized medicine? Where do individual patients and practicing physicians stand in the purported socio-economic-politico-governmental scheme of the "welfare state"? What are the principles, practices, policies, theories, and assumptions underlying this scheme?

Has a thorough study and searching research been made of the prospects and potentials of our economy? Has a comprehensive, full-scope, carefully integrated plan been developed? Or, is the approach being made on a piece-meal, trial and error manner? Is the plan of administration to be paternalistic, benevolently autocratic, tactfully democratic, fair and equitable? Can this be accomplished?

To whose discretion will be ascribed the setting of standards and values, the control of procedures and practices and of resources and means, and management of personnel? Who will be responsible and have the competency to measure results? Who will be competent in performance appraisal?

Who, other than patients and citizens, will pay the costs from their wages, salaries, earnings, profits, or savings? Who is qualified to make beneficial decisions in the sensitive areas of human relations and behavior, wages, hours, price-fixing, and setting of services charges?

What relationship does medical health care and public health have to the elements involved in economics; i.e., poverty, taxes, depressed areas, slums, unemployment (general, sectional, structural), the unemployable, inadequate education, crime, delinquency, wages, hours, and retirement?

Until we learn the structure of this type of scheme, how can we determine whether it is a practical or a political "mix"? Also, how can we determine whether such a scheme is communistic, socialistic, radical, or traditionally American?

Current political efforts to "combine frugality with progressiveness and compassion" are laudable. Experience has made physicians cautious because we are familiar with many shortcomings attendant upon every autocracy.

We also believe, as planned, that depressions and inflationary excesses can be avoided by intelligent teamwork by business, labor, and government leaders. But will it work out that way? Will the principals work for the common good or for self-centered interests?

continued on page 135

Experience has repeatedly demonstrated that a cautious approach in disturbing medical practices is always less harmful, less dangerous, and most often beneficial to the patient—greatly superior to radical, unproven, experimental schemes. How much harm could follow disturbance of our present, superior system of medical care?

We should reexamine and rework the existing programs and resources to apply more beneficially to the critical problems now present. Physicians daily grapple with medical care problems—many secondary to or worsened by socio-economic mishandling or nonhandling. Taking care of first things first has always been effective. Why not have more attention to the first—the economic problems—and then when corrected, look to our great system of medical practice—American style?

Are we correct in believing that the majority of our normal American citizens still prefer to seek welfare, education, recreation, and medical care in their own individualistic separate ways?

It appears timely to make an appraisal of our situation in Wisconsin, to find the facts, weigh the data, and draw upon our community resources —human, professional, intellectual, and financial—to arrive at solutions.

This does not appear to be the time to institute costly, elaborate schemes which are usually incorporated in every sort of health, social, or recreational services. Moreover, many of us are aware of the diminution in the traditional American "optimism and bouyancy" formerly ever-present when working for attainment of our goals.

Other countries show opinions in relationships of health care and other factors. French President De Gaulle recently stated that health research may be a better road to international cooperation than arms control. He recommended the establishment of an international cancer institute.

Hayato Ikeda, when inaugurated on December 9, 1963, for the third time as prime minister of Japan, stated at a post-cabinet meeting press conference that: "He would faithfully carry out promises he had made during the general election to build a *welfare state*, determine and prepare concrete measures for disaster relief, pay raises for public service personnel, . . .

"Our program for creating a welfare state of a high order by achieving full employment and raising the people's standard of living through the *income-doubling* plan has again been endorsed by the electorate. Accordingly, we will push more energetically this program on the basis of the principle of sound economic growth, taking into full consideration past accomplishments and future trends . . . pledging . . . stabilization of consumer prices, expansion of social overhead capital, enlargement of social security, and reduction of taxes . . ."

Ikeda also stated that he would work for: "The principle of respect for human life and freedom can be founded only on the negation of violence. In the light of the recent social trends . . . spiritual rebuilding has assumed a greater importance. The ultimate of 'character building' lies in the perfection of human character through a balanced development of

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URGES SUPPORT OF WORLD MEDICAL ASSOCIATION

With the words "This is your international organization of private medicine as distinguished from the intergovernmental World Health Organization" Dr. Edward R. Annis, President of the American Medical Association, appealed to members of the American medical profession to support The World Medical Association through active membership in The World Medical Association, United States Committee.

Speaking before the AMA House of Delegates during the AMA Clinical Session in Portland, Oregon, Doctor Annis, who is President of The World Medical Association, told of how The World Medical Association is the only private organization officially recognized to represent private medicine on an international level. "Through this representation" he stated, "our own free practice of medicine here in the United States is protected".

Doctor Annis pointed out that by exchange of information and ideas in medicine, The World Medical Association brings together national medical associations representing practicing physicians in fifty-eight countries of the world. The World Medical Association, he noted, maintains a vital role in future planning against disease and in the care of the peoples of the world. As a result, there is better understanding among physicians in the free medical world today.

Physicians in this country, said Doctor Annis, are fortunate to have a means to affiliate directly with The World Medical Association by joining the WMA, U. S. Committee, Inc. Programs and services of the U. S. Committee are of interest and value to every physician in this country and help to accomplish the objectives and goals of The World Medical Association. Membership allows direct participation in several information exchange programs, such as the doctor-to-doctor medical journal exchange, and provides personal contacts with medical counterparts in fifty-eight countries of the world.

United States Committee annual membership dues of $10 are tax-exempt. Dues should be made payable and sent to:

THE WORLD MEDICAL ASSOCIATION
United States Committee, Inc.
10 Columbus Circle
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PRESIDENT'S PAGE *continued from page 135*

intelligence, affection and will power. I have striven to promote nation-building and character-building.

"History never ceases to demand progress and development. We cannot achieve happiness without working for it. It cannot be won without live ingenuity, ceaseless effort, and close cooperation by a large number of people. We should not indulgence in the pursuit of immediate gain; we should strictly refrain from drifting into paths of lease resistance.

"All of us in political life, regardless of party affiliations, have the common duty to serve the cause of happiness and progress of our country and our people. The Diet is the sacred arena for that service. It is not the place for animosity or strife, for disputes or quarrels. It is a place for fair discussions and bold decisions, a place of gallant cooperation. Only in this way can we *demonstrate the true* of parliamentary government and generate the power to cope with whatever situation that may arise."

The above philosophy sounds like good physiology to me and means real competition soon. In this field of complex socio-medico-economics, regardless of all extraneous forces and pressures, I believe it behooves us, as physicians, to get our own house in good order and to continue to improve our housekeeping.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

FEBRUARY 1964

Vol. 63 No. 2

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D. N. GOLDSTEIN, M. D., *Editorial Director*

EDITOR'S NOTE: *Only recently has the enormous potential of clergy-physician cooperation begun to receive the attention it has always deserved. This relatively untapped therapeutic beneficence should be a prime concern of the complete physician devoted to his patient's welfare as a whole person. Encouraging evidence of growing vigor in this direction can be seen in the American Medical Association's new Department of Medicine and Religion. The State Medical Society's Wisconsin Work Week of Health this month features "Medicine and Religion" as one of its five program topics; among the co-sponsors are listed the American Foundation of Religion and Psychiatry, the Diocese of Madison, the Wisconsin Council of Churches, and the Wisconsin Region, National Conference of Christians and Jews. The guest editorialist this month has produced a refulgent summation of the importance of this endeavor. Father John Francis Murphy is an author of books, columnist for* The Catholic Herald Citizen *and a member of the staff of St. Francis Seminary Major Department of Milwaukee.* —*D.N.G.*

GUEST EDITORIAL

Medicine and Morals

■ RECENTLY following a clergyman's summons to the bedside of a critically ill woman, he was accosted in the hospital corridor by a brigade of relatives asking him not to warn the patient of her impending death. "We don't want her to know."

Before he had time to come to grips with any moral responsibilities involved, the issue was settled, for upon entering the sick-room, the patient's first request was that he not warn her family of her real condition. She "didn't want them to know."

Such a situation is perhaps happily more typical than many harried relatives imagine, since most patients, the elderly at least, recognizing artificial nourishment, the need for oxygen, and the loss of strength, realize the value of putting their temporal and spiritual affairs in order.

Some eight years ago a book, edited by Dr. Samuel Standard and Helmuth Nathan, appeared under the title, "Should the Patient Know the Truth?". This helpful sympo-

The Reverend
John F. Murphy

sium by authors of various professions and faiths commented on the twofold aspect of the moral-medical problem, "should the patient be made aware of the possibility of death," and, moreover, "should he be told the precise nature of his illness"?

Some months ago, in the *Wisconsin Medical Journal* (CONFRERES OF THE CLOTH, February 1963, page 139), the very sensible suggestion was made that closer cooperation in this area between doctors and clergymen, especially in the exchange of ideas and knowledge from each group's own particular point of view, might be mutually helpful and ought to be eagerly sought.

In this delicate area of patient welfare, where both legal and moral issues are involved, it is obviously highly desirable that both physicians and clergymen strive to develop such standards, approaches, and techniques as will stand them in good stead in any eventuality. Perhaps certain problems could be obviated if doctor and clergyman alike were able to bank on each others competency and technique, and if, at least in certain areas or institutions, there existed some sort of policy and general procedure normally pursued by everyone involved.

To the moralist, it seems establishable that real charity and concern for a patient in danger of death ordinarily demands that he be somehow informed of his condition. If it is certain that he is spiritually well prepared for any consequences and his temporal affairs are in order, some patients may not require anything more than the most general information.

When it comes to a patient's claim to diagnostic data, it seems consonant with good medical practice and proper morality to handle the situation with great caution. Sometimes such demands for detailed knowledge can be considered unreasonable, and may be properly evaded through legitimate means.

It is highly conceivable that the more empathy an attending physician has for his charge, the less inclined he may feel to indicate the true state of the patient's lot. Moreover, there are some cases where he may feel it is his duty to remain silent or evasive lest his warning do more harm than good.

Basically, of course, the moralist and the vast majority of physicians will insist that in the presumption of approaching death, all other considerations yield to the spiritual welfare of the patient.

Any clergyman, however, would be in a most undesirable position, if through a lack of rapport with physician or policy, or through something of an alarmist approach, he would somehow indicate death to be imminent, only to have the patient recover! A doctor can much better afford to make this kind of mistake in judgment, for his mistake redounds, in a sense, to the value of his own tools and talent.

The physician will understand that the moralist is concerned chiefly with the possibility of spiritual or even eternal harm arising from a patient failing to adequately grasp the gravity of his condition.

At the same time, the clergyman will realize that it is the physician who is allowed to, and even must, use his best judgment as to when, how, and under what circumstances he will advise, whomsoever ought to be advised, of the patient's condition.

In this area of delicate procedure, it will infrequently be the physician or clergyman, or even the patient, who is the source of major difficulties. It is the anxiety of a distraught family that is most likely to conflict with patient welfare or ethical practice.

There are obviously many related points for discussion which this brief essay has not attempted to touch upon at all. It is hoped, however, that more seminars for physicians and clergy will work toward the betterment of medical and moral techniques and obligations. —REV. JOHN F. MURPHY

the wisconsin medical journal

VOLUME 63/NUMBER 3 MARCH 1964

Anaphylactoid Purpura

By GEORGE W. DEAN, M.D., Milwaukee, Wisconsin

■ THE FOLLOWING case is reported because of the unusual and infrequent occurrences of three separate and distinct, but probably related, entities in one person, as well as two severe complications of one of these conditions. We should like to suggest a possible causal relationship between these conditions as well as describe a form of therapy which has been of some apparent benefit to one of them.[1]

Rheumatic fever is a disease of unknown etiology, but there is ample evidence to suggest that it is in some way associated with group A streptococcal throat infections, since its appearance usually follows the occurrence of an untreated streptococcal throat infection. The exact nature of the mechanism which results in tissue damage has not been definitely determined, but there appears to be an antigen-antibody reaction at the site of the sensitized tissues such as the heart valves. Rheumatic fever does not respond to antimicrobial therapy, although statistics show that recurrences can be limited by appropriate long-term antimicrobial drugs. One attack of rheumatic fever does not confer any immunity, and recurrences are said to be more common in those who have suffered a previous attack. Rheumatic fever is becoming less frequent possibly due to early and adequate treatment of the group A streptococcal throat infections.

The relationship of Sydenham's chorea and rheumatic fever has been a rather puzzling one. In some instances of chorea there appears to be a definite association with previous streptococcal infections even though the chorea may occur many months later; in others there appears to be no relationship as determined by culture methods or by determinations of antistreptolysin titer. The latter are referred to as "pure" cases of chorea. From time immemorial Sydenham's chorea has been loosely associated with rheumatic fever as one of the "rheumatic" diseases and it will probably remain there until later evidence results in its disassociation. Chorea has been described as occurring in conjunction with Henoch-Schoenlein purpura and has also been described as occurring with lupus erythematosus. The tendency today is to include more and more diseases of vague or indefinite etiology but with certain related features into a growing group of conditions known as the "hypersensitivity states," and probably the so-called rheumatic diseases will find their niche there.

Henoch-Schoenlein purpura, also known as anaphylactoid purpura, is an uncommon disease occurring chiefly in childhood, episodic in character, and accompanied by purpura, abdominal pain, joint pain, and renal involvement. The purpura at times can be extensive and severe when it is referred to as "purpura fulminans." Renal involvement is one of the more serious complications and can be manifest by hematuria without subsequent nephritis or, on the other hand, serious or even fatal nephritis may follow. In 1808 Willan[2] described a case of purpura accompanied by abdominal pain, nausea, and vomiting. In 1838 Schoenlein[3] reported a

case of purpura accompanied by joint pain and swelling and gave it the name of peliosis rheumatica. In 1852 Johnson[4] observed hematuria in a case of Schoenlein purpura. In 1874 Henoch[5] reported a series of cases of purpura accompanied by colic, bloody diarrhea, joint symptoms, hematuria, and nephritis. In 1915 Frank[6] coined the term "anaphylactoid purpura" to describe this condition. In 1916 Glanzman[7] pointed out the post-infectious nature of anaphylactoid purpura. In 1921 Duke[8] observed that food allergies may possibly be implicated in the etiology of this type of purpura.

The clinical picture of the Henoch-Schoenlein purpura has been extensively documented and will not be reviewed here. The chief gastrointestinal manifestations are abdominal pain of noncharacteristic type often preceding the appearance of the purpura, hematemesis, and melena. Feldt and Stickler[9] reported a series of 139 patients in which there occurred four cases of intussusception. They felt that there was a distinct relationship between the severity of the abdominal pain and the probability of renal involvement.

Renal involvement in Henoch-Schoenlein purpura is a more serious complication which occurs in roughly one-half of all cases. Renal involvement appears to be more common in the older children who acquire this condition and is more common in patients who have severe abdominal pain according to Burke, Mills, and Stickler.[10] The usual manifestations of nephritis include hematuria, proteinuria, azotemia, and hypertension. The nephritis follows a pattern of complete recovery, chronicity, or death from renal failure. Del Rio and Rozman[11] believe that the nephropathy is always an integral part, not an occasional complication, of Henoch-Schoenlein purpura. They described three main forms that the nephropathy may take: hemorrhagic nephritis, chronic glomerulonephritis, or the nephrotic syndrome. Of the 88 patients reported by Burke, Mills, and Stickler, 39, or 44 per cent, had nephritis; 35 of these 39 have been followed and 4 have died of nephropathy. Norkin and Wiener[12] described autopsy findings in two fatal cases of Henoch-Schoenlein purpura. In one there were multiple petechiae, serosal hemorrhages, ulcerations in the esophagus, stomach and intestines, vasculitis and perivasculitis with and without hemorrhages, and evidence of acute glomerulonephritis. In the second case, a 15-year-old girl, there was evidence of severe glomerular damage but no vascular lesions. Norkin and Wiener believe that the Henoch-Schoenlein syndrome is not simply a disorder of cutaneous vessels but that it is a widespread involvement of blood vessels and their endothelial surfaces in various organ systems throughout the body.

Quick[13] described the pathology as "an acute aseptic vascular reaction proceeding in severe cases to necrotizing arteriolitis."

It would appear that the renal lesions, therefore, represent typical acute glomerulonephritis, which may follow a course typical of this disease in any other individual, the Henoch-Schoenlein syndrome and nephritis having a common cause. Some observers of this disease believe that Henoch-Schoenlein purpura and polyarteritis nodosa are closely related, and Gairdner[14] believes that they are the same disease, the capillaries involved in one and the arteries in the other with the arteriolar lesions being observed in both. Vernier,[15] however, believes that the glomerular lesion of Henoch-Schoenlein purpura is not related to acute glomerulonephritis, but that it is a part of the acute vascular disease and more closely resembles the lesions of disseminated lupus erythematosus.

An additional complication of the Henoch-Schoenlein purpura which occurred in the present patient is that of purpura fulminans, characterized by massive subcutaneous hemorrhages which Quick[13] believes is an extreme variant of the Henoch-Schoenlein purpura.

Laboratory studies are of no value in the specific diagnosis of Henoch-Schoenlein purpura with the exception that pathologic examination reflects the abnormal pathologic changes in intestine and kidney. There may or may not be evidence of previous streptococcal infections. Although the capillary fragility may be somewhat increased, thrombocytes, prothrombin, prothrombin consumption, coagulation time, bleeding time, and clot retraction are normal.

Case Report. A white male, now 15 years of age, was seen for the first time in 1958, at the age of 10 years.

His past history revealed that at the age of six months and again at the age of nine months he was hospitalized because of suppurative left cervical adenitis due to hemolytic Staphylococcus aureus. Treatment con-

sisted of incision and drainage, the administration of a sulfa drug and penicillin, and a blood transfusion because of anemia. Urinalysis on both occasions showed a trace of albumin. At the age of six he suffered a severe reaction from smallpox vaccination. At the age of eight he was hospitalized with a tentative diagnosis of rheumatic fever, but the diagnosis could not be completely substantiated by the available laboratory methods.

In 1954, when the child was six years old, purpura first appeared. According to the history given by his parents, episodes of purpura usually followed respiratory infections and treatment was directed at control of the infection. No long-term maintenance therapy of any antibacterial drug was prescribed. Purpura was manifest by excessive bleeding into the skin, melena, and on one occasion by "brown urine." In November 1954, a tonsillectomy was performed after which he seemed to have fewer colds. At that time the urine showed a trace of albumin, bleeding and coagulation times were normal, and the platelet count was normal. Over a period of time his parents subsequently observed that bouts of purpura seemed to occur at intervals of about eight weeks. From time to time superficial infections occurred at the site of the purpura, followed by rather slow healing. In 1955, he was again hospitalized for three weeks with lobar pneumonia and an episode of purpura. At this time a corticosteroid was administered for about one month and some improvement was seen. The Rumpel-Leedes test was positive, persistent hematuria was noted, and there was no heart murmur.

At the time this child was first seen in the office, June 30, 1958, he was literally covered with large purpuric areas involving the skin as well as the oral and nasal mucous membranes. The urine was packed with red blood cells, was dark brown in color but contained only 30 mg. of albumin. He was weak, listless, pale, and appeared badly undernourished. There was a badly infected paronychia on one of the fingers and several scattered areas of an eczematoid rash on the extremities.

At this time it was decided to try as therapy "desensitization" with an autogenous vaccine-filtrate mixture made from the nose and throat cultures, since the history indicated a distinct relationship between respiratory infections and the appearance of purpura. This therapy was instituted July 7, 1958, at one-week intervals. Within a few weeks a distinct improvement ensued, the purpura cleared, the infected nail healed, and his appetite increased. Examination of the urine revealed persistence of protein but no blood. When seen on weekly visits it was noted that an occasional mild cold would be followed by very small purpuric spots on the ankles but these also appeared as a result of trauma such as playing football. In addition to the administration of the vaccine an antibiotic, usually tetracycline, was given during respiratory infections, and this appeared to diminish the intensity and the duration of the respiratory infections.

In April 1959, following an acute respiratory infection he suffered a severe attack of purpura with extensive hemorrhagic involvement in the skin of the extremities and trunk and marked hematuria suggestive of purpura fulminans. At this time he responded promptly to treatment consisting of penicillin, epinephrine, and methylprednisolone. However, following this acute episode gross hematuria persisted for one month and microscopic hematuria and albuminuria for about two months.

On June 25, 1959, he was seen in the office at which time his mother reported that he had become increasingly nervous since the above mentioned severe episode of purpura, the nervousness being manifest by abnormal speech, facial grimaces, and purposeless, clumsy movements of the extremities. The picture was obviously one of Sydenham's chorea. He was hospitalized for two weeks. During this period in the hospital he was afebrile, the sedimentation rate was 30 mm. in one hour (Westergren) on admission and 22 mm. on discharge. The anti-streptolysin titer reached a level of 625 Todd units and the blood cell count revealed only a mild hypochromic anemia. The chest x-ray film was normal revealing a normal heart size and configuration. Repeated urinalyses revealed 1+ to an occasional red blood cell, 1+ to an occasional white blood cell, and persistently 1+ albumin. The platelet count was 211,000. During his stay in the hospital, on several occasions we noted the presence of a transient systolic murmur at the apex with an opening systolic click. Treatment consisted of bed rest and mild sedation. Improvement was very rapid so that at the time of

his dismissal there was a faintly detectable speech defect and occasional slight choreiform movements of the head and extremities. Throughout his hospital stay he was almost afebrile. No purpura was noted during his hospital stay.

He was next seen on August 29, 1959, at which time there was no purpura but he complained of slight soreness in the ankles upon walking for any distance. No chorea was noted and we were unable to detect a heart murmur.

In November 1959, the resumé of his record revealed that since July he had had two respiratory infections, one followed by hematuria and one followed by extensive purpura of the skin. It was felt at this time that the four-week interval between his vaccine injections was apparently too long so this was switched to an injection every two weeks. On this program he did much better with only occasional mild respiratory symptoms and minimal purpura. Repeated examination of the urine revealed persistent mild albuminuria and occasional erythrocytes, but we were unable to detect the heart murmur which had been present in the hospital. His blood pressure remained normal throughout. He attended school regularly, and maintained a paper route delivering 54 papers daily. Occasional small ecchymotic areas were noted about the ankles and lower legs which he attributed to trauma during sports.

A further review of his history up until the present reveals that he has managed very well with only occasional, mild respiratory infections and occasional small ecchymosis about the ankles. He has experienced some respiratory infections without the appearance of purpura. Blood pressure has remained normal throughout this period of time and the last urinalysis revealed no albumin or red cells. It appears for all practical purposes that this is an entirely normal young man.

Discussion. A common precipitating factor appears to group together a number of diseases. The factor is a streptococcal throat infection and the diseases are rheumatic fever, certain cases of Sydenham's chorea, certain cases of anaphylactoid purpura, and possibly acute glomerulonephritis. All cases of anaphylactoid purpura do not fall into the post-infectious type since some have been reported to be on the basis of food or drug allergy. Although the glomerulonephritis appears to follow streptococcal infections, the evidence is not as clearly defined that the mechanism is the same as it is in rheumatic fever. Since nephritis is so commonly associated with the Henoch-Schoenlein purpura, we may assume that we are dealing with a single disease with multiple manifestations or that we are dealing with two separate diseases resulting from a common etiologic agent. The history of our patient leaves no doubt as to the relationship between infections and the occurrence of the purpuric crises. The attack of chorea which he suffered also appeared to follow acute upper respiratory infections by about two months. Paradise[1] has stated that in such an instance chorea may be viewed as neurologic manifestation of the Henoch-Schoenlein purpura or it may occur "as a separate expression of streptococcal hypersensitivity." Paradise further described several cases of chorea occurring in conjunction with lupus erythematosus suggesting a possible etiologic relationship between the so-called rheumatic diseases and the so-called collagen diseases, namely streptococcal hypersensitivity. Cammarata[16] has described a case of systemic lupus erythematosus with chorea. Long[17] has stated that hemolytic streptococci cause rheumatic fever and that streptococcic allergens and toxins act synergistically on mesenchymal cells to produce the rheumatic syndrome in susceptible persons. He further states that susceptibility to rheumatic fever and sensitivity to bacterial allergens are the same, the response to the bacterial allergens being of the tuberculin or cellular type.

Summary. The case history of the illness of a patient manifest by possible acute rheumatic fever, Sydenham's chorea, Henoch-Schoenlein or anaphylactoid purpura and acute nephritis is presented. A probable common etiologic agent is described. A plan of treatment is suggested which has apparently been of benefit in the patient described.

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OBSTETRICAL BRIEF

BACTERIURIA DURING PREGNANCY

By RICHARD F. MATTINGLY, M. D., Milwaukee, Wisconsin

Editor's Note: The following comment on this subject was prepared by Richard F. Mattingly, M. D., Chairman, Department of Obstetrics and Gynecology at Marquette University School of Medicine, Milwaukee, at the request of the State Medical Society's Maternal Mortality Study Committee. The request was prompted by a situation which existed in connection with a maternal death reviewed, and which suggested value in having this topic brought to the attention of Wisconsin physicians, through publication of an OBSTETRICAL BRIEF in the *Journal.* Doctor Mattingly's comments are related to a review of a paper, "Bacteriuria During Pregnancy," by William E. Schamadan, M. D., Columbus, Ohio, which was presented at the annual meeting of the Central Associttion of Obstetricians and Gynecologists in October 1963. Doctor Schamadan has given permission to publish this summary.

* * *

THE INCREASED clinical concern of asymptomatic bacteriuria in pregnancy and its relationship to prematurity and perinatal mortality was the impetus for this study of 901 prenatal patients in the Department of Obstetrics and Gynecology at the Ohio State University Health Center. The incidence of asymptomatic bacteriuria in this group was found to be 6.3 per cent, similar to previous reports in the literature. The diagnosis was made by comparing the microscopic urinalysis, and a stained methylene blue slide test (on air-dried and uncentrifuged urine) with urine cultures. There was agreement among all three methods in 92.4 per cent, and an overall accuracy of 98 per cent when the diagnosis of bacteriuria was made by the stained slide alone, confirmed by urine cultures. The stained slide examined under oil immersion was thought to have the advantage of permitting a more leisure examination of the urine as compared to the wet slide technique, as well as a higher degree of accuracy (98 per cent versus 93 per cent). Forty-one per cent of the author's untreated patients who had bacteriuria were found to develop acute pyelonephritis during the study. Acute pyelonephritis occurred five times more often in the group with bacteriuria than in the group with negative urine cultures.

Of particular interest was the fact that their urine specimens could be kept at 4 to 6 C. for up to two weeks without significant change in the colony counts. Their study was also interesting in the fact that patients with bacteriuria were treated with methenamine mandelate (Mandelamine), and with methenamine mandelate with methionine, with no particular success in eradicating the bacteriuria with these agents, as compared to their controls.

Complications of pregnancy found in their patients with asymptomatic bacteriuria included acute pyelonephritis in 41 per cent; history of previous premature delivery in 26.8 per cent; and proteinuria in 76 per cent. The significance of previous premature deliveries in these is unknown, and the high incidence of proteinuria in the group with bacteriuria was suggested as an index of suspicion of urinary tract infection as well as toxemia. In this group of proteinuric patients, one wonders how many had pyuria as well as bacteriuria.

The paper is timely and informative and suggests another method of diagnosing bacteriuria utilizing methylene blue stained slide technique of uncentrifuged urine. This was found to be more accurate than the time-honored method of the wet slide preparation. It was of particular interest that their incidence of asymptomatic bacteriuria in pregnant patients, as well as the frequency of acute pyelonephritis, was identical to the reports of Kass and others in this group of patients.

Gram-negative Septicemia Including a Case of Acute Endocarditis

By ROBERT J. CORLISS, M. D., Madison, Wisconsin

■ ALTHOUGH the clinical recognition and apparent increasing incidence of Gram-negative septicemia has been stressed in recent reports,[1-8] this entity continues to challenge the clinician.

A high incidence of Gram-negative septicemia occurring in a 450-bed general hospital over a six-month period will be described. The highlights of the previous reports will be correlated with the current data, stressing etiology, diagnosis, management, and prognosis of this ominous state.

Results. Figure 1 presents the total number of cases of Gram-negative septicemia encountered at the Veterans Administration Hospital, Madison, from 1960 to 1963 and depicts the incidence per 1,000 hospital admissions.

In Tables 1 and 2 are listed selected features of 10 cases of Gram-negative septicemia which occurred between July 1, 1962, and Dec. 31, 1962. Table 1 points out the advanced age, the overall mortality of 50 per cent, and the associated hypotension. The underlying diseases are also included since none of the patients were admitted because of the Gram-negative septicemia. It is recognized that this entity has a high association with certain diseases, namely urologic problems, malignancy, and hepatic disease. Eight patients had indwelling urinary catheters. Similarity of blood and urine cultures was noted in 8 of the 10 patients.

Case 9, Table 1, is presented because this patient presents the typical picture of Gram-negative septicemia and demonstrates an unusual complication which is of special interest.

Case Report. A 70-year-old white man had a history of prostatism terminating in complete urinary retention. A Foley catheter was inserted two weeks before his admission to this hospital. The remainder of his history was irrelevant. He specifically denied previous fever, dyspnea, orthopnea, peripheral edema, or history of rheumatic fever.

On physical examination, his blood pressure was 160/80 mm. Hg., temperature 98 F., and pulse 60 and regular. He had a grade 2/6 systolic murmur at the cardiac base with radiation into the neck. The aortic second sound was normal and there was no cardiomegaly. He had grade 2 prostatic hypertrophy. The remainder of the physical and neurologic examination was normal.

Pertinent initial laboratory studies included a white blood cell count of 6,000 per cu. mm. with a normal differential, blood urea nitrogen level of 22 mg. per 100 ml., creatinine clearance 100 ml. per minute, and a negative urine culture. Chest x-ray, intravenous pyelogram, and electrocardiogram were normal. The patient remained afebrile and asymptomatic throughout his diagnostic examination. Benign prostatic hypertrophy was confirmed by cystoscopy and needle biopsy.

Suprapubic prostatectomy was performed 23 days after admission to the hospital. The day after surgery, he developed chills and a temperature of 103 F. with a tachycardia of 110, but he remained alert. His fever persisted and on the sixth postoperative day he was found to have intermittent periods of confusion, atrial fibrillation of 140 per minute, signs of congestive heart failure, and a blood pressure of 85/70 mm. Hg. His white blood cell count was 18,500 per cu. mm., hematocrit reading 32%, blood urea nitrogen level 54 mg. per 100 ml., and a blood culture was positive for *Klebsiella aerobacter*. The patient was digitalized, given diuretics, and 3 Gm. of chloramphenicol was administered intravenously daily. He became normotensive and afebrile. Two days later he

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again developed chills and a temperature of 103 F. Throughout the remainder of his hospitalization his temperature fluctuated between 100 F. and 103 F. A repeat blood culture, 12 days postoperatively, was positive for *K. aerobacter*. Although initial cultures were sensitive to chloramphenicol, subsequent cultures were resistant to this anti bacterial. Courses of tetracycline, streptomycin, and finally kanamycin were administered to the patient. He failed to respond and died 18 days postoperatively.

Autopsy examination demonstrated acute bacterial endocarditis, with a vegetative lesion just below the aortic valve (Fig. 2). There also were multiple ulcers of the gallbladder, acute splenitis with infarcts, and acute pyelonephritis of the right kidney with multiple abscesses. Cultures grew out *K. aerobacter* from all of these sites.

Etiology. The clinical importance of Gram-negative septicemia and bacteremic shock has been stressed by Waisbren.[4] This clinical picture and shock-like syndrome is caused by an endotoxin, a phospholipid-polysaccharide protein complex contained in the cell wall of the Gram-negative bacteria and released when lysis occurs. The endotoxin acts on the vascular bed ultimately producing vascular atony and consequent shock without blood or fluid loss. Experimental work[7,9] has shown this effect to be independent of the nervous system, acting directly upon the vessel walls by enzymatic activity.

Gram-negative septicemia frequently is associated with other diseases with such regularity as to be diagnostically significant. The liver is important in clearing the blood of Gram-negative bacteria and endotoxin. Diseases of this organ consequently are predisposing to Gram-negative septicemia. Genitourinary manipulation offers a portal of entry in an area where the Gram-negative bacillus is prevalent. Malignancy and some hematologic diseases, which are debilitating, lower host resistance. In this series of patients there is a high incidence of associated genitourinary diseases, malignancy, hepatic and hematologic diseases. Similar findings are reported by McHenry[3] in his analysis of 113 cases. The average age of 74 years in our series emphasizes the predilection for the older as well as the debilitated patient.

Although the portal of entry for the bacteria cannot be established with certainty,

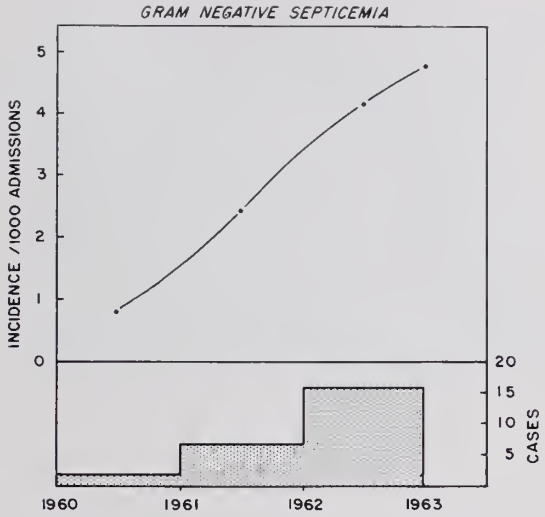

Fig. 1—Shown is the total number of cases of Gram-negative septicemia, Veterans Administration Hospital, Madison, Wis., 1960–1963; also shown is incidence per 1,000 hospital admissions.

it seems that the genitourinary system is the most likely. Slade[10] demonstrated that bacteremia was commonly associated with the placement of urinary catheters. Indwelling urinary catheters were used in 8 of the 10 patients presented in this series. Of the remaining 2, one had immediate antecedent biliary surgery, and the other had a pulmonary infarction and pneumonia with the identical organisms simultaneously cultured from the blood and sputum. In these 2 patients, it is believed that the portal of entry was the hepatic and pulmonary systems, respectively.

In all the other patients, there was no source of entry evident except the indwelling catheters. Five patients with catheters were noted to have bloody urine immediately before the clinical onset of their septicemia. It is of special interest that in 4 of these, the causative organism was cultured from the urine prior to the septicemia. The same organism was cultured from both blood and urine in 7 of the 8 patients in which the genitourinary system was the suspected portal. This offers further evidence that, in these patients, this was the site of bacterial entry. It also emphasizes that urine cultures may give a bacteriologic clue to the etiology of sepsis, especially when the urinary tract is involved.

From this study it is apparent that the present management of indwelling catheters

Fig. 2—Shown is vegetative endacarditis below aartic valve as demonstrated by autopsy examination.

is inadequate. It has been shown that by simple precautions, such as preventing the reflux of urine up the catheters and the maintaining of a closed system, the incidence of catheter-induced infections can be significantly reduced.[11]

Diagnosis. Patients typically will present with chilliness or overt rigors followed by a rise in temperature. Early they also may have vomiting, diarrhea, restlessness, and agitation, but will generally remain alert. They usually have warm flushed skin with full and bounding pulses, although there already may be a reduction in blood pressure. Martin[7,12] reported early leukopenia shortly replaced by leukocytosis. (This was noted in patient No. 2 of Table 1.*) Hyperventilation with respiratory alkalosis was reported as the presenting symptom in Gram-negative septicemia by Simmons.[13] Arterial blood was analyzed in only one of our patients and although he did have respiratory alkalosis associated with a typical picture of Gram-negative septicemia, a single blood culture was negative and he was not included in this study. Clinically, several patients were thought to be experiencing hyperventilation out of proportion to their temperature or degree of acidosis, but they were not studied for this derangement.

Gram-negative septicemia is a diagnostic possibility in all patients with an unexplained febrile, hypotensive illness. Nine of the 10 patients in this series developed some degree of hypotension. In Table 1 are listed the average blood pressures before and the lowest blood pressures during the septicemia. This is a much higher incidence of hypotension than the 30 per cent generally reported.[5,14] It is possible that milder or transitory cases without hypotension remained undiagnosed in this study.

Management. Blood and urine cultures must be obtained and therapy initiated as soon as Gram-negative septicemia is suspected. The management of bacteremic shock consists primarily of antimicrobial therapy and the maintenance of the blood pressure and circulation. Unless there is a previous bacteriologic clue as to the organism involved, such as a positive urine culture, the antibacterial must be chosen on an empirical basis. Spittel and Martin[6] advocate combined antibiotic therapy of 500 mg. of tetracycline every 6 hours and 1 Gm. of streptomycin every 12 hours. An alternate regimen is 3 Gm. of chloramphenicol per day and 1 Gm. of kanamycin every 12 hours. The drugs should be administered intravenously if hypotension is severe enough to impair circulation or absorption. As in any empirically chosen regimen, the therapy needs to be revised if there is no satisfactory response in a given time, arbitrarily 12 hours in this condition. Failure to respond, with prolonged temperature elevation or repeated positive blood cultures, suggests complica-

TABLE 1—*Clinical Features*

Case No.	Age	Sex	Underlying Disease	Blood Pressure: Average before mm. Hg.	Blood Pressure: Lowest during mm. Hg.	Temp. F.	White Blood Cell Count	Outcome
1	73	M	Pancreatitis, emphysema	150/80	90/0	106	31,000	recovered
2	68	M	Malignant lymphoma	140/100	90/60	106	4,500* 16,000	 died
3	69	M	Adenocarcinoma of intestine	110/50	90/60	104[2]	39,000	died
4	70	M	Generalized arteriosclerosis	140/70	100/70	105	9,150	recovered
5	75	M	Urethral obstruction	120/90	90/60	103	8,250	recovered
6	67	F	Pulmonary infarction, pneumonia	140/90	90/0	103	11,400	recovered
7	87	M	Generalized arteriosclerosis	170/90	not recorded	104	8,900	recovered
8	70	M	Benign prostatic hypertrophy	140/70	100/60	105	18,700	died
9	92	M	Arteriosclerosis, chronic brain syndrome	140/80	100/60	104[2]	12,300	died
10	70	M	Glioblastoma multiforme	152/80	70/40	106	9,500	died

tions such as resistant organisms, abscess formation, or endocarditis. Fekety,[15] in his evaluation of colimycin, found this drug worthy of use in patients with *Pseudomonas aeroginosa, Escherichia coli,* and *Klebsiella.* Noall[16] reported successful treatment of a case of Proteus septicemia with a combination of trimethoprim (2, 4 diamino-r-[3, 4, 5 trimethoxybenzyl] pyrimidine) and polymyxin B.

Renal function often is poor initially in patients predisposed to Gram-negative septicemia and can be further compromised by the hypotension. This is of particular importance when drugs are used such as streptomycin, colimycin, and polymyxin B. The poor renal excretion of these drugs in patients with renal failure can lead to severe toxic effects. Consequently, these drugs should be reserved for use only as a life-saving measure in patients with decreased renal function and then used in reduced dosage.[17,18]

The correction of hypotension is essential to maintain adequate circulation before vital organs are damaged by ischemia. Pressor agents generally are used when hypotension develops or if there is a diminution in urine output. Metaraminol (Aramine) can be given either intravenously or intramuscularly and is reported to promote renal blood flow more strongly than levarterenol bitartrate. When effective, this is the pressor of choice. Unfortunately, patients often become refractory to metaraminol and still respond to levarterenol, and the use of the latter is life saving in spite of the experimental evidence of increased mortality with simultaneously administered endotoxin and levarterenol.[7,19]

The theory that blood flow rather than blood pressure is the important factor in shock has led to the use of vasodilators, which is an entirely new concept in therapy. Although lacking the vantage of time, this therapeutic approach is substantiated by experimental studies and clinical observations.[20] The aim is to increase tissue blood flow by blocking the vascular spasm. This treatment is advocated only after patients in shock have failed to respond to blood volume replacement and have evidence of vasoconstriction and sympathetic nervous system hyperactivity. Nickerson[9] recommends administration of phenoxybenzamine hydrochloride (Dibenzyline) in a dose of 1 mg. per Kg. over a period of one-half to one hour. With this, he noted a widening of pulse pressure and gradual rise in the mean blood pressure without additional specific shock therapy.

TABLE 2—*Bacteriologic Findings*

Blood culture organisms	Urine culture organisms	Indwelling urinary catheter
1. Proteus	Proteus	Yes
2. K. aerobacter	K. aerobacter	Yes
3. E. coli	No cultures	No
4. K. aerobacter	Alcoligenes faecalis	Yes
5. Proteus	Proteus	Yes
6. Pseudomonas	Pseudomonas (sputum culture)	No
7. E. coli	Proteus E. coli	Yes
8. Providence group	Staphylococcus aureus Proteus Streptococcus faecalis Providence group	Yes
9. K. aerobacter	K. aerobacter Proteus	Yes
10. Proteus	Proteus	Yes

Administration of large doses of adrenal corticosteroids for short periods of time appear to be helpful in the management of endotoxic shock. When used, 300 to 500 mg. of hydrocortisone or an equivalent analog is required, intravenously administered two or three times daily for the first few days. The mechanism of action is not yet known. It is interesting to note that aldosterone is reported even more effective in protecting against endotoxic shock.[21]

Additional therapy for shock includes wrapping of the lower extremities, utilization of the shock position, and oxygen therapy to combat tissue ischemia.[22] Hypothermia recently has been advocated in the treatment of septic shock.[23,24]

Prognosis. Five of the 10 patients died probably as a direct result of the Gram-negative septicemia. Three of these patients had underlying malignancy, which in itself was considered terminal. Of the remaining 2, one was 93 years old with incapacitating chronic brain syndrome and generalized arteriosclerosis, and the other developed the complication of acute endocarditis. This emphasizes the predilection of this disease for the debilitated patient and the importance of the underlying diseases in regard to the prognosis. The occurrence of shock significantly increases the mortality. The mortality of Gram-negative septicemia is reported to be about 30 per cent. When accompanied by shock, it is twice as great.[14]

Summary. Ten cases of Gram-negative septicemia are presented, including a patient

with acute Gram-negative endocarditis. The clinical features are reviewed and demonstrate the predilection of this entity for the older, debilitated patient. The genitourinary system, particularly when indwelling catheters are used, is incriminated as a frequent portal of entry of the Gram-negative bacillus. The highlights of treatment are discussed stressing appropriate microbial therapy and measures to combat hypotension.

ACKNOWLEDGMENT: The author wishes to extend his thanks to Richard H. Wasserburger, M. D., and Robert O. Burns, M. D. for their help in the preparation of this manuscript.

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NARCOTIC DRUG ADDICTION

A history of narcotic drug use and control and the legal, medical, and social complexities created by drug abuse in the United States is contained in a new book, *Narcotic Drug Addiction Problems*, record of a National Mental Health Institute symposium on the subject.

Many pioneers in each of the major fields of addiction met in Bethesda, Md., in 1958 in the first full discussion by all the professions concerned with addiction.

The review of narcotics addiction in this country and comparisons with drug use abroad was designed to lend perspective to the issues involved. Because the problem has a number of facets, each is usually viewed from the separate experience of narcotics control agents, lawyers, judges, prison authorities, psychiatrists, sociologists, and physicians. The meeting suggested useful points of departure for a more comprehensive approach to the problems of narcotic drug addiction. Although it was held five years ago, "nothing essential is out of date" that concerns these problems, the preface states.

As revealed in the 14 papers and remarks by the participants, the interrelated problems of narcotics addiction have been long entangled around two poles of concern. On the one hand, illicit traffic in drugs is a crime, and on the other hand, addiction may create physical and psychological changes requiring medical care. Among the questions raised was, how to lower the high rate of relapse among addicts after withdrawal treatment? What psychological and social forces combine to initiate addiction? Should the addict have a legal means of procuring drugs? The talks, like the large-scale White House Conference on Narcotic and Drug Abuse held last year, suggested various areas for study, such as the potential usefulness of rehabilitation clinics for addicts.

The book, Public Health Service Publication No. 1050, is for sale by the Superintendent of Documents ($1.75), U. S. Government Printing Office, Washington, D. C., 20402.

The Conquest of Pain: Highlights in Anesthesiology

By JOSEPH C. KISER, M. D.
Madison, Wisconsin

■ AS RECENT as the 19th century, pain, hemorrhage, and infection stood as barriers against technical progress in surgery. Primitive peoples used all kinds of queer concoctions to relieve pain. Rarely did they produce unconsciousness except in lethal doses. Roman surgeons produced unconsciousness by sustained compression on the carotid arteries. This was abandoned, however, since the patient, if he recovered, was frequently paralyzed.

Another technique based on cerebral anoxia, which was employed with less disastrous results by the Romans, was the opening of an artery in the wrist and bleeding the patient into unconsciousness. Still another Roman practice frequently used during the crucifixions, while the victims were hanging on the cross, was the customary practice of giving sour wine which had been drugged with opium or mandragora to deaden the pain. Vinegar and hyssop were offered to Christ on the cross for this purpose.

Opium prepared from poppy seeds was well known and was thought to have been used by Helen to drug the wine which Ulysses drank. Indian hemp or hashish was known to the Egyptians and also to the Arabians. The Hebrews and Babylonians credited mandragora, which they prepared from the mandrake plant, with magical properties. They feared it because of its definite narcotic action. In the book of *Genesis,* Chapter 30, Verse 14, Rachel says to Leah, "Give me, I pray thee of thy son's mandrakes." But in this instance they were desired not for their sleep-producing properties, but because they were also credited with awakening sexual passion and with curing sterility, for Rachel was barren. This plant is found in the Americas as the May apple *(Podophyllum peltatum)*. The variety found in the East is the most active.

In 77 A. D., Dioscorides, botanist and military surgeon in Nero's army, recommended that mandragora be given before any "cutting or burning." He suggested that this preparation be instilled into the rectum, which is probably the earliest recorded instance of rectal anesthesia. The drug remained popular until the 16th century. Mystery always surrounded this drug for the ancients suggested that a dog be tied to the plant as it was harvested, and that when the dog broke loose and pulled the plant from the ground he would give one shriek and then drop dead. Shakespeare mentions it in *Romeo and Juliet*, Act IV, Scene 3, "Shrieks like mandrakes torn out of the earth." By 1800, mandrake had been removed from the official pharmacopeia.

In the 17th and 18th centuries, surgeons became less mystical. Occasionally they intoxicated their patients with alcohol or gave them large doses of opium before operating, but usually they relied on stout ropes or two or three strong assistants. In the English Navy during this period, an ordinary sailor was given a bullet to bite on while petty and junior officers were given rum. The senior officers received rum plus laudanum.

Mesmerism. In 1734, Franz Mesmer was born. He studied medicine in Vienna, and his work on animal magnetism became the subject of heated debate in every European capital. Louis XVI set up a commission to investigate animal magnetism. It is interesting to note that Benjamin Franklin, United States Ambassador to the Court of France at that time, was chairman of the investigating group. An official report was made which damned Mesmerism medically, and a confidential "morality report" was issued which ended Mesmer's career in disgrace. His clinics had been used as meeting places for perverts of all kinds and his practice of

treating hysterical young women in darkened rooms provoked ribald comments. Mesmerism spread rapidly to the United States and was practiced by Charles Poyen in Maine. Poyen interested Phineas Quinby in Mesmerism, and Quinby in turn influenced Mary Baker Eddy who founded Christian Science.

Nitrous Oxide. In 1772, Joseph Priestly isolated nitrous oxide. In 1800, an English chemist, Sir Humphrey Davies, working as an assistant in a pneumatic institution which specialized in the therapy of chest diseases by inhalation of gases, relieved the pain of an infected tooth with nitrous oxide. He published a paper and stated, "As nitrous oxide in its extensive operation appears capable of destroying pain, it may probably be used to advantage during surgical operations in which no great effusion of blood takes place." No one took note of Davies' idea and he himself failed to follow it up.

In 1818, a report attributed to Michael Faraday showed that ether produced essentially the same results as nitrous oxide and this became a fashionable inhalant at "ether frolics." In 1823, an English physician, Henry Hill Hickman, described as being too soft hearted to endure the patient's screams of pain during the operations, placed animals under glass bells and introduced carbon dioxide in an attempt to render them unconscious. Unfortunately, most of his animals succumbed. It would have been a small step from this experiment with gases to the study of other gases, but he did not make this attempt.

Morton, Jackson, Wells. The real tragedy in the epic of the conquest of pain involved Morton, Jackson, and Wells, and began in 1845 in the United States. Prior to the beginning of this tragedy in 1842 Crawford W. Long, a country doctor in Jefferson, Ga., was the first man to operate on a patient whom he had rendered unconscious by the use of ether. He charged $2.00 for the operation and 25 cents for the ether. It was merely by coincidence that Crawford Long used ether in this circumstance. He had a patient with a carbuncle on the neck who was known to indulge heavily in ether spirits. Crawford Long frequently used intoxicating doses of alcohol when operating upon his patients but thought it would be more beneficial in this instance to use ether since the patient was familiar with it. Little note was made of Crawford Long's early work until many years later when there were attempts to establish priority in the field of anesthesia.

In 1844, Horace Wells, a Hartford, Conn., dentist, attended a laughing gas show owned by a man named Colton. In this show, Colton rendered the participants hysterical with nitrous oxide. Wells, while sitting in the audience, noticed that one of the men struck his leg so hard against the table that he sustained a deep laceration without exhibiting any pain whatsoever. Wells went to Colton immediately after the show and suggested that possibly this gas could be used to render patients unconscious for dental extractions. He suggested that Colton come to his office the next morning and they would try it. Thus, on the following morning Colton rendered Wells unconscious with nitrous oxide and Riggs, Wells' assistant, extracted his tooth quite painlessly. Subsequently, Horace Wells became quite popular in Hartford as the "painless dentist."

However, he was not satisfied with this and wanted to make his discovery known. His only acquaintance in Boston at that time was a former pupil named William Morton. Initially he and Morton had owned a workshop for the manufacture of a novel type of denture. Before the dentures could be applied, however, all of the teeth had to be extracted. This was too painful a procedure, and the venture failed. William Morton, in the meantime, had decided that if he were to be successful in gaining the hand of a daughter of a prominent citizen in marriage, perhaps he should go into medicine and forget dentistry. With this in mind, he went to Boston to study medicine.

Horace Wells believed that William Morton, who was in Boston supposedly studying medicine, could arrange entrance for him into the operating amphitheater of John Collins Warren to demonstrate nitrous oxide. With this idea in mind, Horace Wells went to Boston and looked up his former student and partner. As it turned out, Morton had no close contacts with the Boston hospital whatsoever, but he did know a rather prominent chemist by the name of Jackson. Jackson was an interesting character; he was a chemist, philosopher, geologist, and was involved in priority disputes with Beaumont and Samuel Morris. When Morton and Wells approached Jackson for sugges-

tions about the use of nitrous oxide, he ridiculed them and told them if they wished to receive similar pleasures they might try *sulphuric ether inhalation.*

At this point, Morton and Wells temporarily parted company. How Horace Wells finally gained admission in the operating amphitheater of John Collins Warren in January 1845 is not known for certain. Undoubtedly, Warren had been interested in any possible development of a pain-relieving medication for many years but had eventually undertaken the philosophy that surgery and pain probably were inseparable.

During January 1845, Horace Wells attempted to extract a tooth from a patient rendered unconscious with nitrous oxide in the operating amphitheater of John Collins Warren. He was totally unsuccessful, in that, when he touched the tool to the patient's tooth the patient became completely hysterical and ran screaming out of the room. Horace Wells was humiliated and immediately left Boston to return to Hartford. From this time until his death, Horace Wells continued to experiment with various gases including chloroform. Unfortunately, he was not aware of the danger of addiction or brain damage. After one such inhalation of what was probably chloroform, he ran screaming into the streets and threw acid into the faces of some young girls. He was immediately incarcerated, and while in jail his mind cleared temporarily to the extent that he realized his career probably was ruined. He left a long note explaining the experimental work that he had done and with a hat over his face, a handkerchief soaked with chloroform between the band and his nose, he lacerated his left femoral artery with a razor blade on a stick. *This was probably the first suicide under anesthesia in history.*

Ether Anesthesia. In the meantime, William Morton, of a more practical, although psychopathic nature than Horace Wells, realized the possibilities of financial gain in exploiting the use of nitrous oxide or ether as anesthetics. He returned to Hartford and watched Horace Wells use nitrous oxide in his dental practice and on returning to Boston obtained some sulphuric ether from Jackson. After conducting a few experiments on dogs using sulphuric ether, he devised a simple method of inhalation of the gas; it was nothing more than a glass flask with a long funnel and a piece of gauze over the end which contained a sponge soaked in sulphuric ether. In October 1846, William Morton gained admission to the operating room of John Collins Warren and was successful in rendering a patient unconscious while Warren removed a tumor from the neck.

Morton then laid plans for financially exploiting this method of inhalation. Initially he attempted to keep the preparation secret and called it "letheon." It was't long, however, before the medical profession became aware that this "letheon" was no more than sulphuric ether. In the meantime, Morton applied for a patent based on the "method of inhalation" and hoped to link his preparation with the patent. Morton approached Jackson offering him 10 per cent of all income that he hoped to obtain from this business venture provided that Jackson raised no objections to his obtaining the patent in his own name. Jackson consented. On November 12, 1846, a patent was granted on the *method* of administering a narcotic agent.

Oliver Wendell Holmes, sensing the tremendous change that was going to take place in the field of surgery, wrote a letter to William Morton suggesting that he carefully consider the name which he applied to this method of rendering the patient unconscious. He coined the word "anesthesia" (a Greek derivative referring to the state of insensibility). William Morton then abandoned his training altogether and began devoting his time to issuing licenses to hospitals throughout the country for the use of his apparatus.

Truman Smith, a lawyer in Hartford, championed the case of Mrs. Horace Wells during priority disputes which arose between Jackson and Morton. The information brought forth by Truman Smith induced Jackson and Morton to team up and attempt to defeat this new champion of Horace Wells. Later, Morton's patent was annulled in a suit against the New York Eye Infirmary and ether anesthesia was declared public property. A short time after, Morton sued the United States for $100,000 and became obsessed with this fight for "his cause." The dispute over the priority in anesthesia developed national interest. In 1852, Morton's suit against the United States Government came before Congress, and Truman Smith succeeded in defeating Morton. In 1863, Morton once more appeared before Congress with his lawsuit and Truman Smith, now a sen-

ator, again defeated him. In 1868, Morton finally left Washington a ruined man, suffering from severe paranoia. He died at the age of 48 in St. Luke's Hospital, New York; he had been reduced to a pauper.

Jackson outlived Morton by many years, but his rationality was later overpowered by his megalomania. In 1873, he was placed in restraints at McLean Asylum in Boston where he lived the remaining seven years of his life.

The spread of ether anesthesia to England was rapid. In December 1846, Robert Liston introduced ether anesthesia to England by amputating a leg in 28 seconds with the patient asleep under ether. It is interesting that, at the operation in December 1846 by Robert Liston, Joseph Lister, then 20 years of age, was at the foot of the table.

In 1811, James Simpson, who was to have a profound effect upon the field of anesthesia, was born. He studied at Edinburgh University, Scotland, and after failing in attempts to practice pathology and surgery, became prominent in midwifery. He later became chairman of the Department of Midwifery at Edinburgh in 1839 and founded the field of gynecology. Around 1846, Simpson began to use ether anesthesia in obstetrics, but became dissatisfied with it because of its unpleasant odor, the large quantities needed, and the irritating effect on the lungs. Therefore, he and his assistants began inhaling the vapor of almost any volatile gas in an attempt to obtain a more satisfactory agent. The experiments became social sessions and in this setting the anesthetic properties of chloroform were first noted in 1847. Chloroform had been initially isolated independently by three chemists, a Frenchman, a German, and an American, in 1831. Simpson began using chloroform routinely in obstetrics creating a great moral issue regarding the "interference with something which was intended by the Almighty to be painful." Finally this issue was decided in 1853 when Queen Victoria allowed chloroform to be administered to her at the birth of Prince Leopold. John Snow became the Queen's anesthetist and subsequently administered chloroform 4,000 times in 11 years and did research on ether and nitrous oxide as well.

In 1850, Lorenzo Bruno began to use morphine preoperatively to make the anesthetist's task easier. Atropine was also used in early anesthetic times. The date of its first use as premedication is not definite.

The next step in the growth of anesthesia was the development of tracheal intubation and inhalation. During the latter part of the 19th century, Miculicz had developed techniques for resecting the upper end of the esophagus for carcinoma. He desired also to resect the lower end of the esophagus for carcinoma but needed a method to prevent the lungs from collapsing when the chest was opened. Ferdinand Sauerbruck, his assistant, who later became the leading thoracic surgeon in Europe, first developed a close-fitting face mask for this purpose. Later, in 1904, he worked out an ingenious method of keeping the lungs expanded. The entire operating team and the body of the patient was placed in a large negative pressure cabinet with only the patient's head protruding. The patient could not be moved, and the heat was unbearable. This method obviously was not practical. The outgrowth of the method, however, was the iron lung which still is used in cases of respiratory paralysis. Sauerbruck returned to the tight-face mask which had the disadvantages of inflating the stomach and preventing the removal of secretions from the tracheo-bronchial tree.

Tube Inhalation. In the 16th century, a tube in the trachea was first used to keep the lungs inflated during anatomical demonstrations; since there was no anesthetic agent in use at that time, its use in anesthesia was never suggested. In 1871, Friedrich Trendelenburg placed a tube (with an inflatable cuff) into the trachea through an incision in the neck and the outer end was attached to a gauze mask. This technique was developed to allow surgery on the upper respiratory tract without fear of aspiration of blood. In 1878, McCuen made the next major advance by inventing a tube of flexible brass which could be passed into the trachea through the mouth by a sense of touch. The patient's coughing efforts then were quickly suppressed with chloroform.

In 1899, Rudolph Matas adapted the Fell-O'Dwyer apparatus for endotracheal anesthesia. This was a combination of Joseph O'Dwyer's endotracheal tube and George Edward Fell's bellows for artificial respiration. The positive pressure produced would keep the lungs inflated when the chest was opened. In 1895, Tuffier in Paris added the

inflatable cuff to the endotracheal tube of this apparatus for positive pressure methods. In 1895, Kirstein introduced the laryngoscope, and the endotracheal tube now could be introduced through the mouth under direct vision. In 1901, Franz Kühn emphasized the necessity of a wide tube to allow easy expiration as well as inspiration and, in 1902, showed how the tube could be passed through the nose. Kühn also introduced the use of cocaine as a local anesthetic agent prior to intubation. In 1907, Barthelemy and Dufour introduced insufflation intratracheal anesthesia delivering gas to the lungs under pressure by squeezing a hand bulb. Expiration took place back up the trachea around the outside of the tube. In 1908, Franz Volhard suggested the importance of a rhythmical action in order to allow carbon dioxide to be eliminated from the lungs.

The classic work of Samuel James Meltzer and John Auer of Rockefeller Institute appeared in 1909. They elucidated much of the physiology of respiration and demonstrated that ventilation could be maintained in the animal breathing air under pressure without respiratory movements on the part of the animal. Prior to World War I, few surgeons were prepared to undertake the risk of chest surgery. After World War I, McGill and Robotham, working at Sir Harold Gillies' plastic surgery hospital and using insufflation endotracheal technics, found that fewer complications were experienced with the return to the inhalation endotracheal method with the patient breathing through a wide bore tube. They clinically popularized this method. In 1936 McGill introduced intermittent suction through a catheter lying in the endotracheal tube for the removal of secretions.

In 1932, Ralph Milton Waters of Wisconsin introduced one-lung anesthesia with an inflatable cuff tube passed into a main stem bronchus. In 1938, Clarence Crawford introduced a machine which controlled respirations, and as recently as 1941, Michael Dennis Roseworthy achieved control of respirations and popularized the "bagging technique." No machine has completely satisfactorily replaced this method. Initially drugs were used to suppress and control respirations centrally. Now the muscle relaxants bring about complete paralysis of the respiratory movements giving the anesthetist as complete control of the patient as is desired.

Local Anesthesia. The Incas of ancient Peru chewed coca leaves and applied this spittle to the skull to reduce the pain of trephination. In 1855, a chemical substance responsible for this action was extracted by a German chemist. Four years later, another German chemist, A. Niemann, isolated this substance in pure form and called it cocain. Little attention was paid to it, however, until 1878, when Vassely Konstantinovich Aurep demonstrated its anesthetic properties on animals and suggested it might be used on humans. In 1884, Karl Koller at the Ophthalmologic Congress at Heidelburg read an account of his own success in anesthetizing the conjunctiva and the cornea.

This news immediately reached the United States. Halstad in New York began experimenting with it in 1884 to prove it safe for injecting into tissues around nerves. He saw the tremendous advantages of local anesthesia over the more dangerous, poorly developed general anesthesia. Halstad and Richard Hall and their colleagues worked at Roosevelt Hospital experimenting upon themselves by injecting a dilute solution around peripheral nerves. Gradually they developed regional block anesthesia. Unfortunately, they were not aware of the danger of addiction of this drug. Their achievement for humanity was at the expense of great personal disaster.

Halstad alone among them, and only after retiring from practice for a year, overcame the addicting properties of the drug. After retiring from practice for one year, he was invited in 1887 by William Welch, his old friend, to come to a beautifully equipped laboratory at Baltimore. In 1889, he recovered sufficiently to return to active practice as an associate professor at Johns Hopkins. Later, he was commended by the Dental Association as the "father of local anesthesia." In the years that have followed, many well-known synthetic agents with action similar to cocain have been developed, but which lack its addicting properties.

1912 Atwood Avenue (4).

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: PHILIP G. PIPER, M. D.

Madison, Wisconsin

Case Presentation.* A 60-year-old white man was first admitted to the hospital on Apr. 27, 1962, with a history of sudden onset of moderately severe left upper precordial pain radiating to the left arm and from the front to the back of the left upper chest, lasting 15 to 20 minutes. There was also associated precordial oppression, headache, and slight blurring of vision. He had been treated with bishydroxycoumarin (Dicumarol) for the past three months for "a small stroke" characterized by the sudden onset of bilateral dimness of vision which disappeared gradually over a period of two weeks. There was no other previous history of coronary or cerebral disease. Systemic review and family history were not remarkable. There was no family history of coronary disease, hypertension, or diabetes.

On initial physical examination he was found to be oriented and alert although moderately apprehensive. He had no dyspnea and his color was good. His blood pressure was 162/100 mm. Hg. Funduscopic examination revealed Grade 2 vascular changes. The pupils were equal and active bilaterally. The thyroid was slightly enlarged to palpation and slightly nodular. The lungs were clear. Examination of the heart revealed a regular rate of 84 with no murmurs; aortic second sound was slightly increased. The liver was barely palpable on deep inspiration. The dorsalis pedis pulses were absent bilaterally. There was definite acrocyanosis of the feet with pallor on elevation and rubor on dependency.

Routine laboratory studies on admission revealed normal urinalysis with specific gravity of 1.010; hematocrit reading 37%; hemoglobin level 13.9 Gm. per 100 ml.; white blood cell count 8,850 with 42 segmented neutrophils, 2 band forms, 4 eosinophils, 49 lymphocytes, and 3 monocytes; erythrocyte sedimentation rate 43 mm. in one hour; prothrombin time 25.5 seconds (control 12.0); blood urea nitrogen 42.6 mg. per 100 ml.; blood sugar 99 mg. per 100 ml.; serum glutamic oxalopyruvic transaminase (SGO-T) 22 and serum glutamic pyruvic transaminase (SGP-T) 20 units. Five days later the SGO-T was 22 and the SGP-T was 16 units. Initial electrocardiographic studies revealed inverted T waves in standard lead 1 and AVL, and precordial leads suggestive of an anterolateral infarction. Subsequent tracings revealed progressive healing of an anterior wall infarction.

The patient was treated with bed rest and anticoagulant therapy, had an uncomplicated hospital stay and was discharged on May 18, 1962. He had no further angina but presented a persistent elevation of his sedimentation rate and blood urea nitrogen. His urea clearance was 22.6 (24% of normal). It was believed that this was due to nephrosclerosis. His sedimentation rate at the time of discharge was 50 mm. in one hour, blood urea nitrogen 55, and serum uric acid 8.2 mg. per 100 ml. The patient was readmitted on the evening of May 31, 1962, because of the relatively acute onset of epigastric and right upper quadrant pain associated with dyspnea and slight nausea which began four hours before admission. He had no vomiting and no change in his bowel habits.

On admission there were livid spots noted on his flanks and legs. The patient was responsive but very apprehensive. His blood pressure was 150/80 mm. Hg. There was no cyanosis or diaphoresis; only a few moist rales were heard at the lung bases. The heart presented a regular apical rate of 108 beats per minute with no murmurs or friction rub. There was no dependent edema. The nail beds appeared pale but were not cyanotic. He had slight hepatomegaly on percussion. No bowel sounds were heard.

The chest film on admission revealed marked generalized cardiomegaly and bilat-

* From Madison General Hospital.

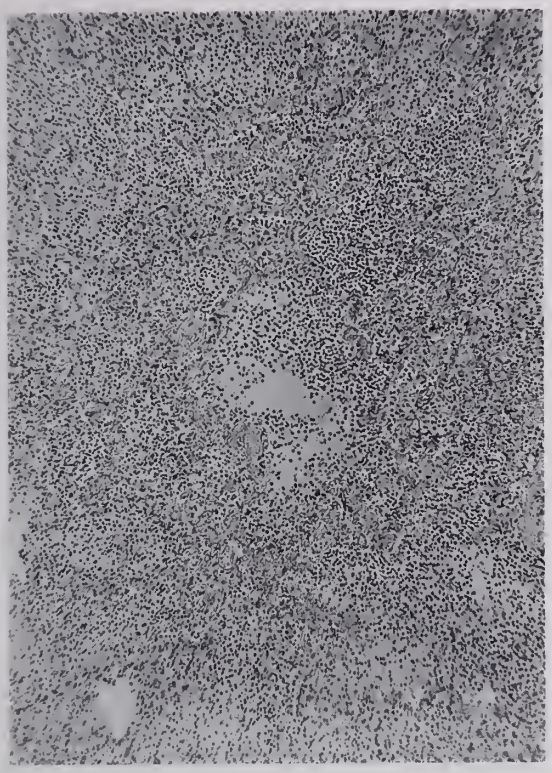

Fig. 1—Section of lung showing confluent bronchopneumania.

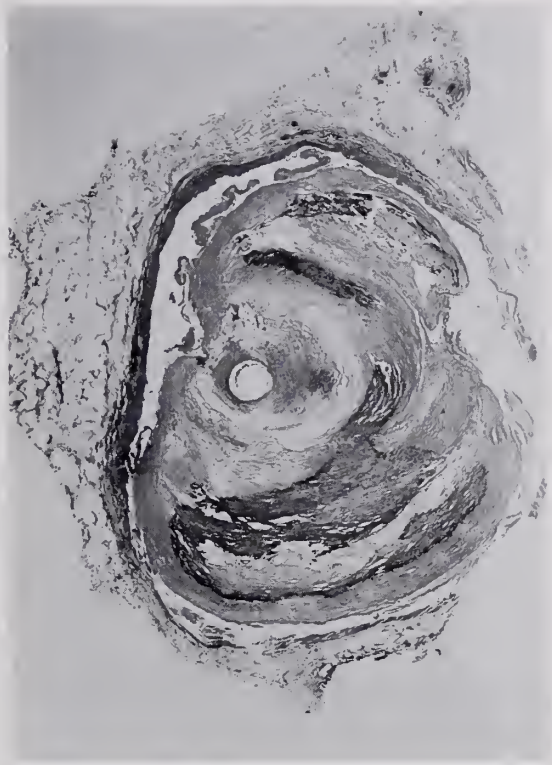

Fig. 2—Caronary vessel showing advanced arteriasclerosis and recanalization.

eral pulmonary congestion. Nasal oxygen was started, and he was given 0.8 mg. digitoxin intramuscularly, followed by 0.4 mg. digitoxin in 12 hours. He was also given 75 mg. of meperidine hydrochloride (Demerol) intramuscularly for restlessness. Within 40 minutes the patient's condition was much improved. An electrocardiogram taken the following morning revealed considerable improvement from the initial electrocardiogram, in that all T waves were upright; there was slight depression of the ST segments from the effect of digitalis. There was no evidence of a recent infarction. Bed rest, digitalization, and sodium warfarin (Coumadin) therapy were continued.

The following day increasing dyspnea, abdominal bloating, and cyanosis were noted by the nurses. Examination revealed a moderate pallor, moist and cool skin, but there was no cyanosis. His blood pressure was 178/100 mm. Hg., the heart rate 104 and regular. There were still moist rales at the lung bases bilaterally.

Laboratory returns on June 1, 1962, were: blood urea nitrogen, 60 mg. per 100 ml.; prothrombin time, 26.3 seconds; SGO-T 42, SGP-T 24, and serum amylase 170 units; hematocrit reading, 31%; hemoglobin level, 10.2 Gm. per 100 ml.; white blood cell count, 13,800 with 74 segmented neutrophils, 5 band forms, 1 basophil, 1 eosinophil, 14 lymphocytes, and 5 monocytes. During the next few days the patient remained apprehensive and had a persistent tachycardia of 104 to 110 per minute. His pulse slowed gradually with carotid sinus pressure.

Follow-up electrocardiograms were unremarkable. A progress chest film on June 4, 1962, revealed the heart size to be within normal limits with the pulmonary congestion cleared. A unit of packed cells was given two days later, following which the patient had a minimal urticarial reaction. His drowsiness became more pronounced. The blood urea nitrogen level rose to 95 mg. per 100 ml. on June 5. His urine output remained approximately 1,500 to 1,800 ml. until June

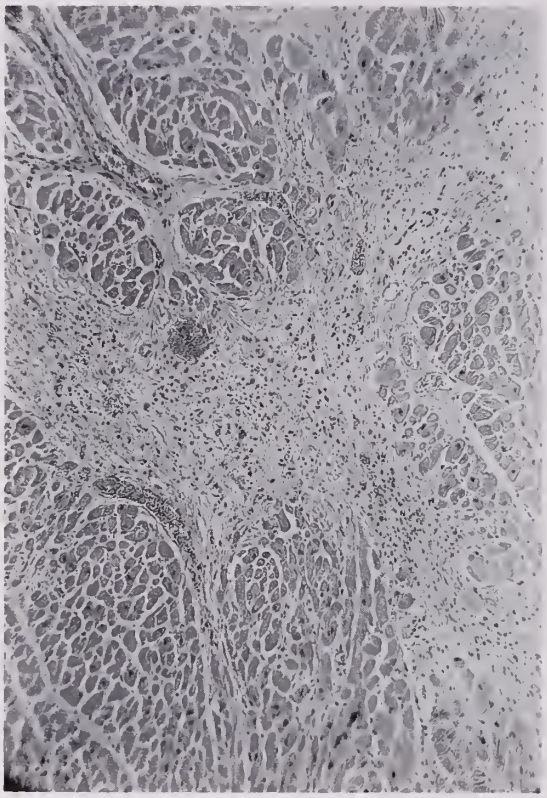

Fig. 3—Section of myocardium with focal hemorrhage and leukocytic infiltration in the fibrous septae.

Fig. 4—Section of right temporal lobe showing diffuse hemorrhagic alteration of the brain tissue.

24 when it was only 500 ml. Two stool specimens were strongly positive for occult blood on June 9. He was given two units of packed red blood cells, and there was no further occult blood noted in his stools on subsequent examination. Anticoagulant therapy was stopped. His hematocrit reading returned to normal after the transfusions, but his blood urea nitrogen level remained elevated at 104 mg. per 100 ml.

Although he remained responsive and alert when aroused, mild Cheyne-Stokes respirations began on June 12. At that time a limited upper gastrointestinal x-ray examination revealed only some deformity of the duodenal bulb. On June 21, he had a normal sinus rhythm, 90 per minute. He was moderately drowsy but easily aroused. On June 22, prothrombin time was 23.1 seconds. On June 23, he had a hemoglobin level of 10.5 Gm. per 100 ml. and a blood urea nitrogen level of 108 mg. per 100 ml. He was given another unit of packed red blood cells.

It was noted that on June 24, there were multiple petechiae on the extremities. On June 25, the patient appeared much more lethargic and had facial edema. The toes were moderately cyanotic and again there were multiple petechiae on the legs. An electrocardiogram on June 26 revealed an anteroseptal wall infarct as noted in previous tracings, and there were runs of ventricular tachycardia from alternating ventricular foci. The basic auricular rate was 200 and regular. At this time the patient appeared to be terminal with a flaccid paralysis on the left side, a widely dilated pupil of the right eye, and a blood pressure of 130/190 mm. Hg. On June 25, laboratory returns were: hematocrit reading 36%; platelets 164,000 per cu. mm.; white blood cell count 10,780 with 65 segmented neutrophils, 14 eosinophils, 18 lymphocytes, 3 monocytes; and blood urea nitrogen 118 mg. per 100 ml. The patient died that day.

Dr. R. C. Schmitz: Examination of the chest film revealed the heart to be enlarged in all dimensions. There was some bilateral pulmonary congestion. Findings in this case

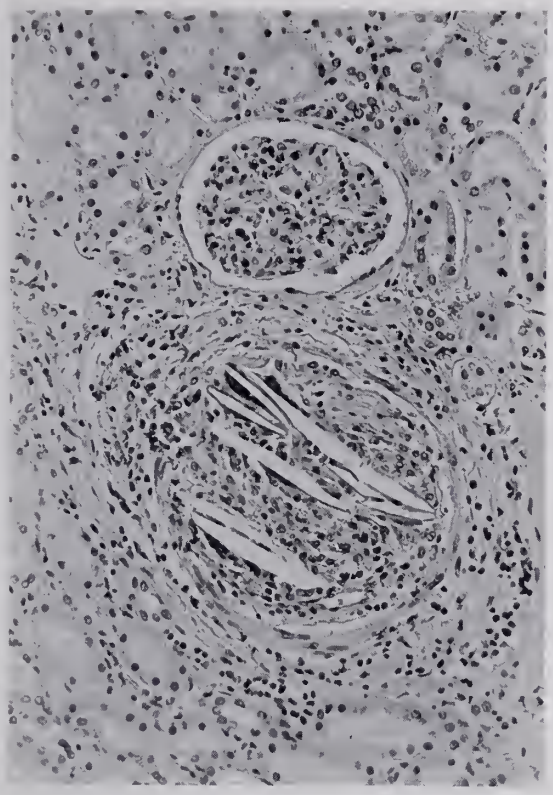

Fig. 5—Renal section showing atheromatous embolus within an artery.

Fig. 6—Pancreatic tissue showing atheromatous emboli within two small arteries.

were suggestive of azotemia. The other possibility would be pulmonary congestion and edema as a result of cardiac decompensation. There was a little fluid in both sulci. The upper gastrointestinal films and films of the abdomen were noncontributory.

Dr. R. H. Wasserburger: Our discussion will concern itself with a series of "medical crises" occurring in a 60-year-old white man, culminating in his death. The patient had led an active healthy life until stricken by a "small stroke" five months prior to his death. This episode was characterized by the sudden onset of bilateral dimness of vision, which gradually cleared over a two-week period. There was no associated muscle weakness or loss of consciousness. He was placed on anticoagulant therapy at that time, which was continued after hospital discharge. Three months later he was again hospitalized for evaluation and treatment of moderately severe left upper precordial pain, sudden in onset, which radiated upward to the left arm and through to his back. The pain lasted approximately 20 minutes and was associated with a mild headache and minimal blurring of vision.

Physical examination at this time revealed the patient to be a well developed, well nourished white man, who was alert but moderately apprehensive. His blood pressure was recorded at 162/100 mm. Hg. with Grade 2 retinal arteriolar changes. He was seemingly well compensated from the cardiac standpoint, and no mention was made of cardiac enlargement. His aortic second sound was tambour, suggesting a dilated and tortuous aorta; and most pertinently, his dorsalis pedis pulses were absent bilaterally.

His initial electrocardiogram revealed inverted T waves in leads 1, AVL and V3 through V6, suggesting an acute anterior wall myocardial infarction. Serial SGO-T and SGP-T determinations, however, were normal. Additional pertinent laboratory data included a hematocrit reading of 37%, an elevated sedimentation rate and a blood urea nitrogen level of 42 mg. per 100 ml.

Following admission, he was placed at bed rest and was continued on his anticoagulant therapy. He experienced no recurrence of chest pain; and although his blood urea nitrogen and erythrocyte sedimentation rate levels remained elevated, he was discharged three weeks later.

Hospitalization was again necessary two weeks later for evaluation of acute epigastric and right upper quadrant pain of 4 hours duration, with associated dyspnea and nausea. Pertinent physical findings included rales at both lung bases, a regular heart rate of 108 per minute; and minimal but definite cardiomegaly, all suggesting cardiac decompensation. His blood pressure was 150/80 mm. Hg. No bowel sounds were heard, livid spots were noted over both flanks and upper thighs, and the fingernail beds appeared pallid.

A posteroanterior chest film confirmed the presence of cardiac decompensation, with marked bilateral pulmonary congestion and generalized cardiomegaly. His initial response to digitalization, nasal oxygen, and meperidine hydrochloride was gratifying, and a progress electrocardiogram showed improvement in his previous anterior wall myocardial infarction. The following day he experienced an episode of increasing dyspnea and abdominal bloating. He became diaphoretic and pallid, with an apparent fall in his blood pressure. Pertinent laboratory data at this time confirmed a further fall in his hematocrit level to 31%, and a rise of his blood urea nitrogen level to 60 mg. per 100 ml. A progress chest film revealed considerable clearing of the previously noted pulmonary congestion and a return of the overall heart size to normal. Once again, there was no electrocardiographic evidence of a progressive myocardial infarctional process. A falling hematocrit and repeated guaiac positive stool specimens led to the administration of 3 units of packed red blood cells. Anticoagulant therapy was discontinued with a subsequent cessation of gross gastrointestinal tract bleeding. An upper gastrointestinal series, although limited in extent, showed no evidence of an intrinsic lesion, with only minimal deformity of the duodenal bulb.

For the next two-week period, his urinary output began to fall slowly, with a rise of his blood urea nitrogen levels to 95 mg. per 100 ml. He became progressively more lethargic, with intermittent episodes of Cheyne-Stokes respirations. A second fall of his hematocrit level led to the administration of one additional unit of packed red blood cells, which was followed by the development of multiple petechiae on the lower extremities.

Facial edema and peripheral cyanosis were noted one day prior to the patient's death, with intermittent runs of ventricular tachycardia documented by electrocardiographic study on the day of his death. Terminally, he developed a left-sided flaccid paralysis, with a widely dilated pupil of the right eye and he died on June 26, 1962, three weeks following his last hospitalization. His hematocrit reading and blood urea nitrogen level the day prior to death were 36% and 118 mg. per 100 ml., respectively.

Discussion. *Doctor Wasserburger:* Can the entire clinical picture of this 60-year-old white man be best explained on an inflammatory, a neoplastic, an autoimmune, or a degenerative disease process? An advanced degenerative vascular disease involving the patient's major arteries is the most likely explanation. His initial expression of vascular disease consisted of a transitory episode of bilateral blindness without motor signs, suggesting involvement of the basilar artery and its branches, the posterior cerebral arteries. He was mildly hypertensive at this time and most pertinently had absent dorsalis pedis pulses, suggesting the presence of advanced degenerative vascular disease. In addition, he exhibited a tambour aortic second sound. I would prefer to think that this initial episode of basilar artery insufficiency was on a thrombotic rather than a hemorrhagic or embolic basis.

His second major episode appeared to be a straight forward myocardial infarction, which, upon electrocardiographic review, I would place in the anteroseptum of the left ventricle rather than the anterolateral wall. This, of course, could give rise to, or explain, his entire subsequent clinical course, with the development of a mural thrombus at the infarctional site and resultant multiple embolic phenomena. The radiation of the chest pain through to the back, with associated blurring of vision, would at least suggest the possibility of a dissecting aneurysm involving the proximal aorta and its primary branches. Subsequent roentgenographic study, however, showing a normal aortic

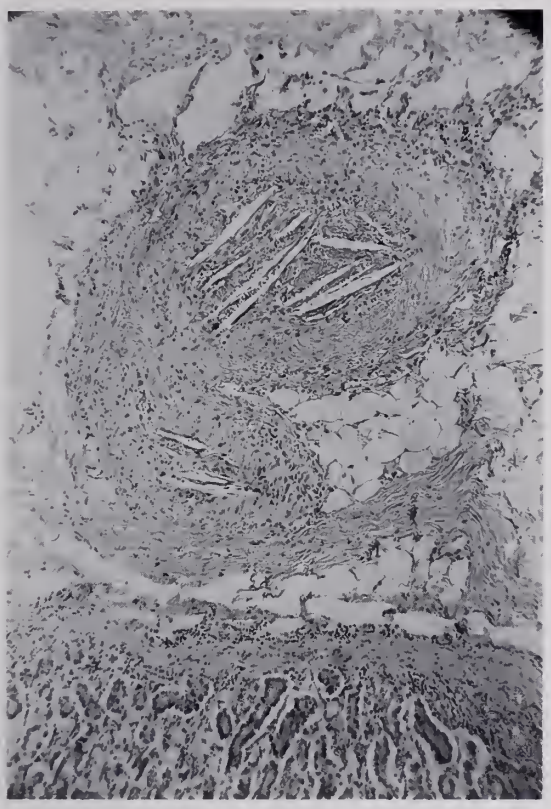

Fig. 7—A section of duodenal submucosa with atheroembolus in an artery.

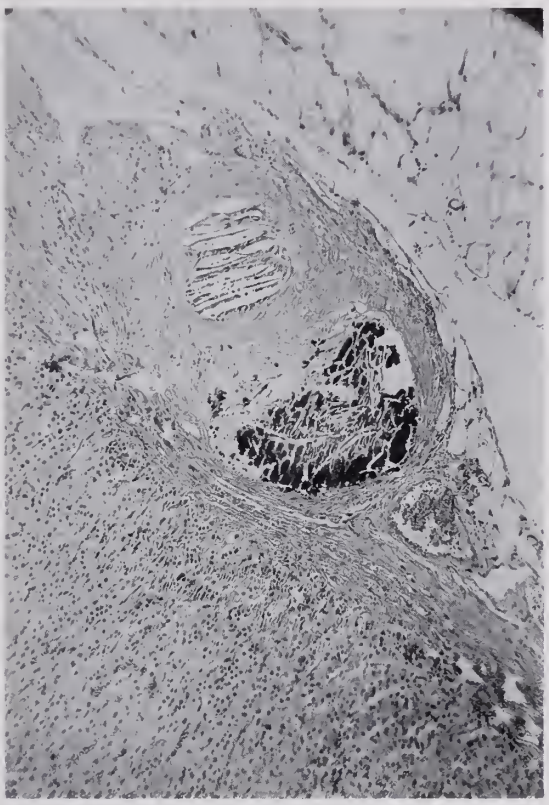

Fig. 8—Periadrenal section with atheromatous embolus and mineral deposition within an artery.

root, tended to exclude a significant dissection.

His third major episode, although complicated by acute congestive heart failure, suggested an acute mesenteric artery obstruction, with considerable weight given to the presence of a "silent," distended abdomen. The presence of a normal sinus heart rhythm and congestive heart failure would favor a thrombotic process, whereas the history of a 5-week-old myocardial infarction with possible mural thrombus would favor an embolic lesion, the anticoagulant therapy not withstanding.

His fourth major episode was concerned with gastrointestinal tract hemorrhage. Attempting to place his disease process on a common ground, I would consider that he was experiencing multiple thrombotic or embolic lesions to the mesenteric arterial tree, with the bleeding enhanced by the sodium warfarin therapy. The cessation of gross gastrointestinal bleeding upon discontinuing his anticoagulant therapy seemingly would support this premise, although an occult neoplastic lesion involving the colon obviously cannot be excluded.

His terminal picture was that of progressive renal failure, with a rising blood urea nitrogen level and decreasing urinary output. Initially, his physician believed that nephrosclerosis (renal atherosclerosis) was the most likely explanation for the elevation of blood urea nitrogen recorded during his second hospitalization. I would certainly agree, but the subsequent relatively rapid course of renal failure suggests additional factors. Here again, I would consider either multiple thrombotic lesions superimposed upon an ulcerative atheromatous process or embolic lesions involving the aorta at the level of the renal arteries, or involvement of the renal arteries primarily, without total occlusion, or at best, occlusion of only one renal artery.

His fifth and immediately terminal event was the advent of an ominous cardiac arrhythmia, ventricular tachycardia, and a

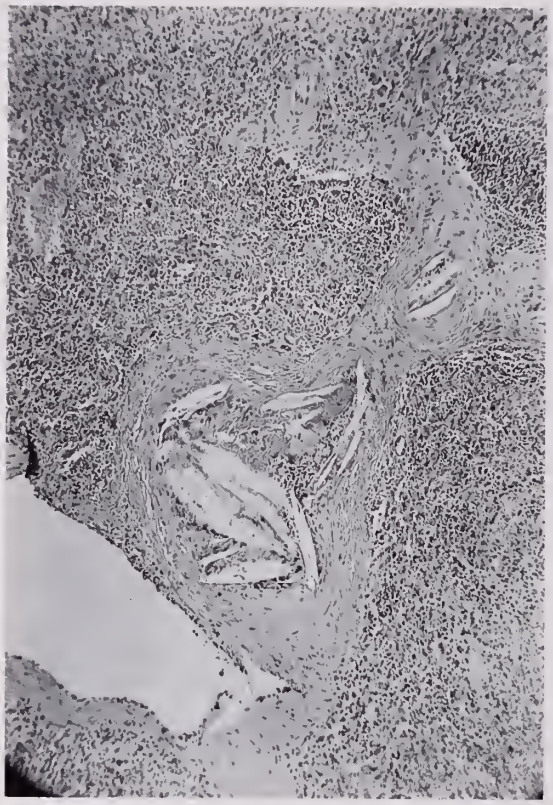

Fig. 9—Atheromatous emboli within fibrous septal arteries of the spleen.

massive cerebrovascular episode. An extensive intracerebral hemorrhage secondary to vascular rupture, or a cerebral infarction secondary to a thrombus in situ, or an embolus secondary to the arrhythmia must be considered. Without knowledge of the cerebrospinal fluid, however, I hesitate to be more specific; but I would favor an intracerebral hemorrhage.

Summary. *Doctor Wasserburger:* I believe that this patient had and died of the common complications of advanced degenerative vascular disease, contrary to his family history. We are given no history of diabetic mellitus, myxedema, or gout which might give rise to accelerated atherosclerosis; and most interestingly, no mention is made of the patient's serum cholesterol level which might point to exogenous or familial hypercholesterolemia. I would like to entertain a more exotic diagnosis, but as I stress to the medical students, interns, and residents, "think of common diseases and their unusual manifestations, rather than common manifestations of unusual diseases."

Thus, if our premise is correct, the patient should exhibit extensive atherosclerotic disease at autopsy, with particular involvement of the aorta and its primary branches, the coronaries, the renal arteries, the basilar and middle cerebral arteries, the mesenteric arteries, and the descending aorta.

The heart should disclose an old anteroseptal wall myocardial infarction, and I suspect that all coronary arteries will show variable and rather extensive atherosclerotic disease, with considerable patchy myocardial fibrosis, to account for the frank congestive heart failure noted shortly prior to death. I would also anticipate a mural thrombus at the site of the previous myocardial infarction as a possible source of emboli. I cannot discount completely the possibility of a dissection of the thoracic aorta, but at this time I can do no more than mention it. I do not think that if one is found, it will be a major consideration. The renal and mesenteric arteries should show variable degrees of occlusion, superimposed upon extensive degenerative and ulcerative atherosclerosis, with a similar disease process present in the vessels of the lower extremities. A massive intracerebral hemorrhage is also anticipated upon section of the brain.

I obviously cannot exclude variants of arteriosclerotic disease, particularly a giant cell aortitis, Takayasu's disease, or a necrotizing arteritis. It would appear reasonable to anticipate a more exotic impression of arterial disease other than simple atherosclerosis to warrant presentation of this particular patient.

This man, although chronologically 60 years of age, "had a vascular tree of a man much older than he, and a fate all too common to many like you and me."

Pathologic Discussion. *Doctor Piper:* I wish to commend you on your analysis of this most interesting case, with special reference to your comment of thinking about common diseases and their unusual manifestations, rather than common manifestations of unusual diseases. I think we shall see from the postmortem findings in this case, that the former concept is the correct one. The body was that of a well nourished, well developed white man, appearing older than his stated age. The general examination of the body presented no distinguishing alterations. The

only significant lesions were those of the extremities in which scattered petechial hemorrhages were present over the arms and legs, as well as on the torso and neck. Except for 20 ml. of clear, straw-colored fluid present in the left pleural cavity and evidence of a terminal bronchopneumonic process involving primarily the lower lobes of both lungs, no other changes were evident in the thoracic cage. On microscopic examination of the lungs (Fig. 1), a focal and confluent bronchopneumonia was identified along with an accentuation of fibrous tissue proliferation in the interalveolar spaces. On examination of the heart, which weighed 420 Gm., an area of softening was evident over the anterior surface in the midportion, involving an area 3 cm. in diameter. It was well located in the anterior wall of the left ventricle. The valvular measurements were within normal limits. The dissection of the coronary arterial system revealed advanced athero- and arteriosclerotic alteration to the point of almost complete obliteration. The anterior descending branch immediately beyond the point of bifurcation contained calcific, as well as soft, atherosclerotic plaques which completely occluded the lumen. It was felt that this latter lesion was responsible for the area of softening and the gross and microscopic changes of myocardial infarction. A section taken through one coronary vessel, proximal to the point of complete occlusion, revealed advanced atheromatous and calcific involvement of the vessel wall with the luminal diameter reduced to only a slit-like space of recanalization. For the most part, the myocardium was fibrotic and in the area of softening, described above, there were minimal to moderate numbers of acute and chronic inflammatory cells (Figs. 2 and 3) found within the fibrous septa which surround the muscle bundles.

The dissection of the aorta revealed diffuse arteriosclerotic and atheromatous involvement with large areas of ulcerations. The centers of these ulcers were filled with a yellow grumous material which could be easily expressed. All portions of the aorta were involved from the arch to the bifurcation.

The brain weighed 1,440 Gm. and the spinal fluid was blood tinged. There was marked flattening of the cerebral gyri, and a pressure cone was present over the cerebellar tonsils. Multiple sections through the cerebral hemispheres revealed extensive areas of encephalomalacia, and an area of intracerebral hemorrhage was found occupying the anterior aspect of the right occipital lobe and the posterior aspect of the right parietal and temporal lobes. It extended from the midportion of the basal nuclei into the posterior portion of the occipital lobe. The brain tissue within the center of this area was necrotic and contained several large organized blood clots. The source of the hemorrhage could not be identified, and there was extension of the hemorrhage into the ventricular system, with moderate displacement. Smaller spherical and flame-shaped hemorrhages were found in the pons and cerebellar peduncles. The medulla and upper cervical cord were free from any gross or microscopic alterations. The microscopic sections through the involved brain revealed marked nerve cell degeneration and evidence of a diffuse hemorrhagic lesion (Fig. 4). For the most part, the cerebral vessels showed minimal to moderate atherosclerosis with some focal areas of calcific deposition, primarily in the basilar artery. No point of occlusion could be identified in any of the vessels examined.

The most pertinent findings involved primarily the arterial system of the kidneys, pancreas, stomach, duodenum, periadrenal tissue, and the spleen with multiple foci of atheromatous embolization in various stages of development. The organs most extensively involved were the right and left kidneys. In each, the capsule stripped with ease, presenting a fine granular surface which contained occasional yellow punctate areas. On section, there was indistinct differentiation between the cortical and medullary portions. The average depth of the cortex in each kidney measured 5 mm. in thickness. Throughout the renal parenchyma ill-demarcated, yellow spherical shaped areas of discoloration were identified. The pelvis and ureters were unremarkable. On microscopic examination of the kidneys, multiple vessels (Fig. 5) contained atheromatous emboli surrounded by multinucleated foreign body giant cells and mononuclear cells. In most vessels, there was almost complete obliteration of the vascular lumen by cellular proliferation and cholesterol deposition. Multiple small diffuse areas of infarction were present, and in each instance they could be traced to the obliterated vessel supplying the area. The inflammatory infiltrate was composed mostly of neutrophils and chronic inflammatory cells

with an occasional eosinophil. The areas of infarction were manifested by degenerating tubules surrounded by chronic inflammatory cells. In some blood vessels marked atheromatosis completely obscured the lumina. Most of the glomeruli were well preserved, although an occasional one showed hyalinization. There was focal basement membrane thickening, and a few glomerular spaces contained pink proteinaceous material. Similar material was found in the focal renal tubules. Other tubules contained acute inflammatory cells, and erythrocytes were seen in the submucosa of the renal pelvis.

Although the pancreas revealed no gross changes, on microscopic examination one large arterial channel at the head of the pancreas contained a hyaline degenerative process in its wall. This was associated with an endothelial proliferation which contained many erythrocytes and cellular debris. Chronic inflammatory cells were found surrounding the vessel and in focal areas of the pancreatic parenchyma. Acute inflammatory cells were also seen in the parenchyma which surrounded many of the small vascular channels containing atheromatous emboli (Fig. 6).

Several small arteries in the submucosa of the stomach at the base of small ulcerations contained acicular spaces, hyalinized material, and mononuclear cells similar to those described in the kidneys. There were vessels (Fig. 7) in the duodenal submucosa containing similar material, although no erosion of the associated mucosa was identified.

The adrenal glands were grossly unremarkable but on microscopic examination in the periadrenal arterial channels atheromatous emboli were also identified. One vessel (Fig. 8) contained mineralized material within the lumen.

The spleen was of normal size, shape, and configuration. The capsule appeared focally fibrotic, and on cut section there were no gross changes visible. Microscopic examination of the splenic parenchyma revealed several arteries (Fig. 9) to contain acicular spaces surrounded by multinucleated foreign body giant cells and mononuclear cells with no associated panarteritis.

The gross and microscopic findings within the liver did not reveal the presence of this process and were, for the most part, unremarkable.

It was our conclusion that the atheromatous lesions described above were all secondary to embolization from the aorta.

Diagnosis. *Doctor Piper:* The pathologic histology presented in this case substantiated Doctor Wasserburger's concept that the patient had, and did die from, complications of advanced degenerative vascular disease. Unfortunately, a blood cholesterol was not done during his hospital stay so these values were not available to us. The primary cause of death, of course, was attributed to the cerebral vascular accident associated with major secondary considerations of myocardial infarction and renal failure.

The entity of atheromatous embolization was first described in detail in this country by Flory[1] in 1945, when he reported 9 cases of arterial occlusion by emboli from eroded atheromatous plaques of the aorta. Since that time, cases have been reported with increasing frequency and approximately 100 cases have been studied up until 1960.[2] It has been found to occur predominantly in males over 60 years of age who were suffering from severe aortic atherosclerosis, although the atheromatous material may also originate in the systemic arteries.[3] Embolization of atheromatous material in most cases occurred spontaneously, but it may also occur as a consequence of surgical manipulation of diseased arteries.[4] Because the abdominal portion of the aorta usually revealed the greatest involvement in atherosclerosis, the organs most frequently affected by atheromatous embolization were those supplied by this segment of the arterial system. In 59 cases which went to autopsy, the sites of involvement were as follows: kidneys, 43; pancreas, 37; spleen, 34; gastrointestinal tract, 11; brain, 10; thyroid, 9; liver, 9; prostate, 8; heart, 7; bone marrow, 6; lower extremities, 6; adrenals, 6; gallbladder, 5; and testicles, 2.[2] Syphilitic involvement of the proximal aorta accounted for most of the cases of cerebral or coronary emboli.

The basic histologic picture varied according to the age of the lesion. In the typical early lesion the arterial lumen was filled with large cholesterol acicular spaces surrounded by hyperplastic intimal tissue, foreign body giant cells, and occasional mononuclear cells in an otherwise structurally intact small artery. These spaces were identified as containing cholesterol crystals by the use of polarized light on frozen sections. The fact

that the occlusive lesions were embolic and not a form of local atherosclerosis was evident from their intraluminar position and because of the maintenance of the structural integrity of all layers of the involved artery. During the acute phase, a panarteritic process with a conspicuous neutrophilia and eosinophilia can be found. Occasionally, secondary necrosis of the vessel wall occurred.[3,5,6] The possibility that this was due to an allergic response to the body's own protein which was present in the atheromatous material was unknown.[3]

In older lesions the giant cells disappeared and the crystals became enveloped by connective tissue. The lumen could be reestablished but it was often compressed and tortuous, or eccentric in character. The pathologic sequelae were variable. A minority of investigators believed the emboli were innocuous in the majority of instances, postulating that they were fast converted to a soluble stage and disappeared.[5] The more popular feeling, however, was that more often undesirable pathologic alterations occurred, the nature and extent of which depended upon the site and the degree of involvement. Tissues distal to the lesions became ischemic and resulted in atrophy and necrosis.[7] Some of the disease states attributed to cases of atheromatous embolization were coronary occlusion, encephalomalacia, gangrenous changes in the lower extremities,[8] ulceration of the intestinal mucosa, chronic pancreatitis,[2] acute pancreatitis,[6] renal hypertension,[7] and renal failure.[2,4]

It was of interest to note that in the patients described by the many authors the cause of death was often directly related to vascular disease and its complications, such as encephalomalacia, myocardial infarction, or renal failure.[2] It has been reported that identical lesions have been produced in the lungs of rabbits by injecting suspensions of atheromatous material into the ear veins.

Question from the audience: Have any cases been reported of atheromatous embolization occurring as a sequela to manipulation of the abdominal wall during a physical examination in cases of advanced aortic disease?

Doctor Piper: From our review of the literature, no such cases have been described, but certainly by inference such manipulation could act as a trigger mechanism to produce multiple emboli of this type in the various body organs. I would like to ask Doctor Valdivia for a comment concerning this interesting lesion, since I know he has studied a number of cases.

Dr. Enrique Valdivia: We do not know if this was a significant factor in our particular 7 cases. The lesion was an incidental finding in the kidney in the first case. Then we found similar lesions in the spleen of the same person. The second and third cases presented terminal renal failure; the lesions were more recent and numerous than in the first case. Two of our 7 patients had no renal failure. All of them were elderly men. The microscopic appearance of the lesions varied from old recanalized lesions to granulomatous reaction simulating arteritis. Some of the recent lesions showed minimal inflammation.

ACKNOWLEDGMENT: The author wishes to thank Dr. Jean Lang, a senior resident, department of pathology, Madison General Hospital, for her cooperation in preparing the presentation and investigation as to references and complete work-up of the case.

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COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Analgesics for the Relief of Pain

I. NARCOTIC ANALGESICS

By RICHARD I. H. WANG, M.D., Ph.D., Milwaukee, Wisconsin

■ PAIN IS MISERY. Relief of pain will, of course, follow the cure of the responsible disease, but this is usually slow while the need for the control of pain is frequently urgent. When definitive therapeutic measures for the treatment of pain are not available or of no value, pain can be controlled by means of nonspecific therapy, such as physical methods and/or analgesic drugs. The commonly employed physical methods are immobilization, rest, diathermy, massage, elevation, traction, and manipulation. The analgesic drugs consist of both the narcotics and the nonnarcotics.

Various aspects on the nature of pain and the use of analgesics in the treatment of acute and chronic pain have been reviewed recently.[1] In this report a survey of the high spots of the currently used analgesic drugs is presented under the medicolegal classification of narcotic (addicting) and nonnarcotic (nonaddicting) analgesics.

1. Narcotic Analgesics probably act either by modifying the central perception of pain or by changing the reaction of the individual to pain. They produce euphoria in patients with pain but frequently dysphoria in patients without pain. Incidence of their side effects is generally higher among ambulatory patients. The presence of severe pain at the time of the administration of a therapeutic dose of these agents rarely if ever leads to an alarming degree of respiratory depression. The real shortcoming of these agents is the imminent possibility of producing tolerance, physical and mental dependencies. The narcotic analgesics are comprised of the opiates and the opioids.

A. Opiates have an oxyphenanthrene ring in common.

1. *Morphine* remains popular because its efficacy and side effects are well known and besides the use of morphine is quite economical. When the patient has no difficulty in its ingestion and also absorption, it can be administered orally (about twice its usual subcutaneous or intramuscular dose).

2. *Codeine* (methylmorphine) is the most frequently prescribed opiate. The hypodermic dose of codeine is twice as effective as an analgesic as the same dose given orally.[2] Incidence of addiction is comparatively lower than for morphine.

3. *Dihydromorphinone* (Dilaudid) has less sedative effect than morphine at an equianalgesic dose level. Its onset of action is faster but the duration of action is shorter than morphine.

4. *Oxymorphone* (Numorphan) resembles dihydromorphinone. It is the most potent analgesic in terms of milligram potency.

B. Opioids are synthetic analgesics with four basic types of molecular structures—the piperidine, morphinan, benzomorphan, and diphenylheptane derivatives.

1. *Meperidine* (Demerol) enjoys its popularity among opioids because it was introduced first. The duration of action is about 2 to 4 hours. Like morphine it produces a rise in intrabiliary pressure. It may be administered orally (about twice its usual hypodermic dose).

2. *Alphaprodine* (Nisentil) has a very short duration of action, 1 to 2 hours, and is chiefly used in obstetrics.

3. *Anileridine* (Leritine) is well absorbed in the gastrointestinal tract. Depending upon the severity of pain, its oral dose ranges from 25 to 75 mg. every 4 to 6 hours.

4. *Piminodine* (Alvodine) except with higher milligram potency differs very little from meperidine.

5. *Levorphan* (Levo-Dromoran) probably has more sedative effect than morphine. The oral dose is the same as the hypodermic dose, 2 to 3 mg., because it is well absorbed from the gastrointestinal tract.

6. *Phenazocine* (Prinadol) is a potent analgesic on a milligram basis. It may have a lower incidence of side effects than morphine. It is administered by the parenteral route only.

7. *Methadone* (Dolophine) is well absorbed by the gastrointestinal tract. Its oral dose varies from 5 to 15 mg. given every 4 to 6 hours. It produces less euphoria and sedation than morphine.

*The Estimated Equianalgesic Dose of Narcotic Analgesics**

Name	Source	Dose (mg.)
Morphine	U.S.P.	10
Codeine	U.S.P.	60
Dilaudid	Knoll	2
Numorphan	Endo	1
Demerol	Winthrop	75
Nisentil	Roche	50
Leritine	Merck	40
Alvodine	Winthrop	20
Levo-Dromoran	Roche	2
Prinadol	S.K.F.	2
Dolophine	Lilly	10

*Equianalgesic dose is an approximate equivalent in analgesic effect of 10 mg. of morphine administered subcutaneously in the control of pain.

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VERTEBRAL ARTERY INSUFFICIENCY

Doctors Marvin Wagner and Earl Kitzerow of Milwaukee County General Hospital reported a case of vertebral artery insufficiency in the December 1963, *Archives of Surgery*. The causative factor was cicatraces about the vertebral artery due to hemorrhage after a thyroidectomy.

At the time of his right subtotal thyroidectomy, the patient had a postoperative hemorrhage and was returned to the operating room for control of bleeding from the right inferior thyroid artery.

The patient had episodes of headache, lightheadedness and near syncope. Bilateral carotid angiograms showed no abnormalities. Aortic arch studies were performed employing retrograde brachial angiography, and an occlusion of the right vertebral artery was noted. This occlusion was visualized only when the patient turned his head to the right.

When the neck was explored, cicatricial bands were noted about the right vertebral artery, which twisted and occluded the artery at the point of fixation when the head was turned to the right. These cicatrices were lysed. There was no recurrence of symptoms postoperatively.

The authors stressed the importance of visualizing the entire brachiocephalic run-off in patients suspected of having cerebral symptoms due to extra-cranial vascular disease, and that retrograde brachial angiography is an excellent procedure in one's armamentarium for such study.—V. S. Falk, Jr., M. D., Edgerton.

DELAY BARIUM ENEMA AFTER RECTAL BIOPSIES

Amer. J. Digest Dis. 8:882, (Oct) 1963.

In some clinics it has been the practice to refer patients after a rectal biopsy immediately to the radiology department for barium enemas. This sequence of events is followed because of a desire to complete as rapidly as possible the study of the entire colon. Drs. Samuel D. Hemley and Virginia Kanick of the St. Luke's Hospital, New York, consider such a sequence of events undesirable and dangerous. According to their observations "a rectal biopsy produces a localized area of traumatized, weakened bowel wall. If within a few hours or days this weakened area is subjected to increased intraluminal pressure (such as occurs even with a routine barium enema), the possibility of perforation is great."

The New York physicians describe the history of two patients who developed perforation with extravasation of barium into the perirectal tissues after a barium enema had been instilled immediately after a rectal biopsy. Both patients developed peritonitis and died subsequently.

Because of the experience described it is now the practice at the St. Luke's Hospital to delay a barium enema study for at least fourteen days after a rectal or sigmoid biopsy.

THE PRESIDENT'S PAGE . . .

The Practice of Organized Medicine

■ WE PHYSICIANS INHERITED our State Medical Society from our physician predecessors, thereby becoming the leaders in the practice of medicine. Whether we like it or not, we can never divest ourselves of the mantle of leadership in health care of Wisconsin citizens.

Leadership is essential, for without it nothing would be accomplished and medical affairs could become chaotic. Leaders are needed for effectiveness. Each physician maintains his or her own individuality.

All too few physicians are carrying the heavy load of organized medicine in our communities. Many fear that organized activities will interfere with the individualized practice of medicine, preferred by most of us. In reality, a strong case can be made for the concept that physicians can be more individualistic within organized medicine than in private practice. Many have little or no knowledge of the structure, constitution, bylaws, or performance of our State Society. More lamentable is the fact—fully verifiable—that the majority of the membership gives little or no attention or thought to the State Medical Society.

The management of organized medical activities is a "natural" for physicians. Their training in the basic sciences, their education and training in clinical medicine, and in proper methodology in research prepares them ideally for managerial functions. The records show that a physician can accomplish much more for humanity within organized medicine than he can when practicing "solo." Successful management depends upon the ability to "get others to do things," demonstrating the value of the art of persuasion. We do these things daily in diagnosis, treatment, and prognostication of problems. Such activities encompass the bases of sound managerial procedures.

In addition to diagnostic competence, experience, knowledge of the behavioral sciences, and knowledge of interpersonal and intergroup reactions are the factors influencing decision-making. Physicians can still retain their individualities, for organized medicine is the reflection of the sum-total of the individual physician members and their attitudes and behavior.

The standards, values, policies, principles, practices, and other realities must be established by the physician members—i.e., a medical rationale, a philosophy of medicine, which must at all times be dominant in medical care.

A climate for warmth of spirit, of and between the members, should be encouraged—improved and maintained to improve the Society's functioning. This temperate climate will be helpful in eliminating or mitigat-

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PRESIDENT'S PAGE *continued from page 166*

ing conflicts as much as possible. Misconceptions and misunderstandings can be avoided or corrected. A temperate climate is supportive, encouraging objective discussions and diminishing any contentiousness which interferes with proper Society procedure. Such a climate facilitates the meeting of challenges in the best interest of society. Human relationships are the crucial features of effective handling of all situations and for achievement of our objectives. Activities can be carried out logically in a rational manner, with respect for individual emotional states, and also respecting all states of "feelings." Organizations are so complex that we must focus on the "feelings" daily in all interpersonal and intergroup activities at all levels and must always be wary to avoid any unintended consequences.

Members who feel inexperienced in organizational work can learn by study, by trial and error, by working with the Society, or by personal observation.

When policy and principles are established, understood, and communicated where due, then executive action comes into play. The duties and responsibilities of executives are well established and are available through many sources. Management is bound legally and ethically by certain rules, laws, customs, and traditions, as well as the Code of Ethics. A person in the capacity of director or a trustee is liable unless prudent and diligent at all times—no excuses are readily acceptable. Organizations, while ancient in origin, are peculiarly American in scope, extent and usage.

Of immediate concern to physicians, in private practice as well as organized practice, is the rapid emergence of management tools, apparatus, and techniques in the automation field. The use of these adjuncts puts more of a load on management, for what is fed into the units determines the degree of correctness that comes forth.

The use of accountants to control and check finances is universally accepted by physicians and supplementary medical groups. A new control or checking process is developing steadily. This has been called an appraisal of performance—a performance audit. Such an audit would be applicable to our Society, for in an economic classification we would be listed as a "service" activity. A study and analysis is made of the accomplishment of certain activities, common to associations.

For instance, a study of a meeting of a committee is made. The amount of preparation time, the actual meeting time used, the time spent after the meeting, how and why the meeting was held, the size (how many there and time), must be compared with the results as recorded in the minutes. When the results of the study are made available to the organization, the results are immediately improved—better premeeting preparations, careful recording of minutes relative to each action.

Each association will be greatly improved when meetings are conducted effectively by experienced leaders. A leader must have the ability to maintain objectives and to be objective in viewpoint (may be difficult). He must keep "on the track" and get the meeting back on when it goes "off the track." He must contrive to have each attendant contribute and have respect for busy physicians' time away from practice. To achieve results he must have the ability to analyze, identify and explain various factors and possibilities, costs, results (immediate, remote), to translate information and opinions, recommendations, resolutions and motions. He must indicate who should be at such meetings and indicate when expert

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INTERNISTS ORGANIZATION BACKS USE OF NEW MEDICAL AGENTS

The American College of Physicians (ACP), representing specialists in internal medicine, says a physician's use of new medical techniques and agents is "a proper and indispensable part of the practice of medicine."

Action of the ACP Board of Regents, backing clinical investigation of new drugs and methods of treatment, was announced January 14 by Wesley W. Spink, M.D., Minneapolis, Minn., president of the internists' organization.

Doctor Spink, Professor of Medicine at the University of Minnesota, made his remarks at a two-day ACP regional meeting in New York City.

A resolution, passed by the ACP Board, voiced the feeling that the future progress of medical science depends on a three-step chain reaction involving various stages of new medical developments. And the lack of any one step affects the progress of medical science.

The chain reaction consists generally of the discovery and development of new or improved medical techniques, procedures and agents, followed by the early or investigation phase, and finally, their acceptance and usage by the medical profession.

General acceptance, according to the resolution, "must be preceded by an early or investigational phase to demonstrate the utility of such new technique, procedure or agent in the normal course of diagnosing, treating or preventing a disease state as it occurs in humans."

The resolution concluded:

> "The use of new or relatively new medical techniques, procedures and agents which, on the basis of reasonably probative data, offer reasonable promise of conferring patient benefit at least equal and possibly superior to that obtainable through the use of established techniques, procedures and agents without a correspondingly greater foreseeable risk to the patient, is hereby approved as forming a proper and indispensable part of the practice of medicine."

The American College of Physicians, which has headquarters in Philadelphia, Pa., represents more than 12,300 specialists in internal medicine and related fields.

PRESIDENT'S PAGE *continued from page 167*

knowledge or consultation is indicated. He will know that improvement in work follows only after scientific measurement is applied to determine time necessary, results obtained, functions and services, decisions and valuations, and resultant short-term and long-term plans formed.

It will be difficult for the busy physicians to function most effectively unless communications are timely and adequate. To remedy this hazard it is beneficial to set up a comprehensive management reporting program form. This report should contain all necessary or requested information, data, and facts and figures. The information should be well reported in a readily readable, assimilable form sent immediately, for old statistics are cold and difficult to use in comparative activities.

For the future, let us try to single out and encourage our most competent and potentially effective members to join the squad so that we shall always have a superior team for patient good. Such a team will explore and study all facts before becoming involved in any changes, and it may be able to help us develop greater feelings of responsibility for the greater effectiveness of our organization.

All in all, the work with organized medicine is difficult, but the challenges that are met and the splendid colleagues you meet and work with make the fast-moving time very pleasant. The best way to learn the practice of organized medicine is to experience it yourself by going to work with it anywhere, anytime, in our state.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

MARCH 1964

Vol. 63 No. 3

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Burning Issue

■ NOW THAT THE Surgeon General's report on smoking has confirmed to the public what had been general knowledge for a long time, it will be interesting to see what action the federal government will take against a demonstrated health hazard.

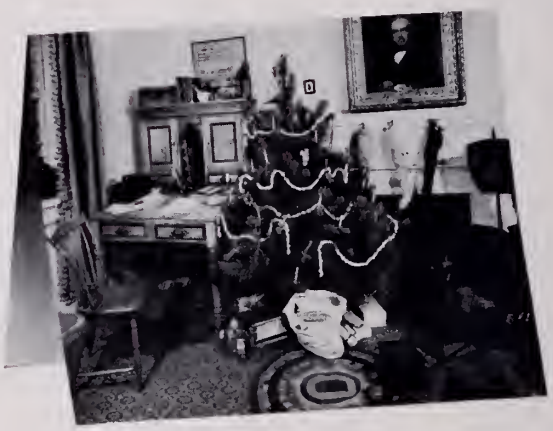
Obviously, a ban on the sale of cigarettes can't be legislated: the sad experience of the Volstead act suggests that making the use of cigarettes illegal might lead to an era of smoke-easies, butt-leggers, and secret inhaling. By printing a message of warning on each package, the cigarette manufacturer would merely underline the hazard the smoker chose to ignore when he bought the pack of cigarettes in the first place. In fact, the only reasonably positive measures the government can undertake are educational in nature. Against the counter-education of the Madison Avenue professors, who work for much higher wages, the government's warnings would probably have the effect of a flute in a windstorm.

The government can, however, take certain negative measures through the Federal Trade Commission and the Federal Communication Commission. Within legal limits, the advertising of tobacco companies could have the same limitations imposed upon it as has the liquor industry's advertising. As no ad ever shows a person drinking beer, wine or whisky, so ads should be prevented from depicting anybody actually smoking a cigarette. Suppression of advertising copy to the effect that smoking is a concomitant of enjoyment, a hallmark of glamor, or a mark of virility should go a long way toward making cigarette puffing attractive only to confirmed smokers. It's the occasional smoker, the beginning smoker, the non-habitual smoker who can be saved from cigarette addiction, and the ban of no-holds-barred advertising might do the trick.

Whatever measure the government takes, the action of our media of communication with regard to tobacco advertising will be a significant note on their sense of responsibility toward the health and welfare of the public. In the face of the proven fact that cigarette smoking may be injurious to many people, will newspapers, radio and television networks, and magazines continue to accept the same kind of cigarette advertising as they have done in the past? Or will they have the integrity to sacrifice a part of their income for the sake of the public good? Will they do it voluntarily or will it require a legal decision? —D.N.G.

A Unique Christmas Card

with a
medical
theme



A full-color presentation of an 1850 physician's office at Christmastime, from an authentic setting at the Museum of Medical Progress in Prairie du Chien. Especially designed by the Charitable, Educational and Scientific Foundation for use by physicians.

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A Special Project of the Woman's Auxiliary
TO THE STATE MEDICAL SOCIETY OF WISCONSIN

(Proceeds will support special projects as designated by the Woman's Auxiliary)

ANNUAL MEETING...

State Medical Society of Wisconsin

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

ANTHONY R. CURRERI, M.D._____Modison
Choirmon

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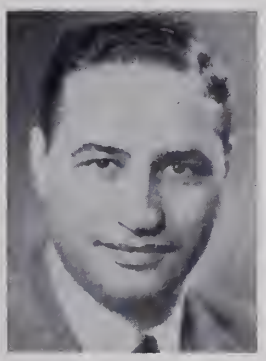


A. R. Curreri, M.D.

P. T. Blond, M.D.

J. K. Curtis, M.D.

G. E. Collentine, Jr., M.D.

MILWAUKEE AUDITORIUM
HOTEL SCHROEDER

Milwaukee

Monday, Tuesday, Wednesday

MAY 11, 12, 13, 1964

House of Delegates Session
(see details on page 181)

SCIENTIFIC PROGRAM

AND RELATED ACTIVITIES

Monday, May 11

A.M.

8:00—REGISTRATION
MILWAUKEE AUDITORIUM, Kilbourn Street Entrance

8:30—EXHIBITS OPEN
BRUCE HALL—MILWAUKEE AUDITORIUM
(Those registering early are urged to view the Scientific and Technical Exhibits on display)

9:30—SPECIAL PROGRAMS ON OBSTETRICS AND GYNECOLOGY AND PEDIATRICS

I. SPECIAL PROGRAM ON OBSTETRICS AND GYNECOLOGY: *PREGNANCY WASTAGE*

PLANKINTON HALL—MILWAUKEE AUDITORIUM
(Program planned in cooperation with Wisconsin Society of Obstetrics and Gynecology)

Chairman: F. JACKSON STODDARD, M.D., Milwaukee, President, Wisconsin Society of Obstetrics and Gynecology

9:30—*The Effects of Drugs on the Human Pregnant Uterus*

RICHARD W. STANDER, M.D., Associate Professor of Obstetrics and Gynecology, University of Indiana Medical Center, Indianapolis, Ind.

(continued on page 173)

1964 Annual Meeting Timetable

SUNDAY, MAY 10

p.m.
6:00 Buffet supper for Delegates and Officers: Hotel Schroeder
7:00 First Session of House of Delegates: Hotel Schroeder

MONDAY, MAY 11

a.m.
8:00 Registration: Milwaukee Auditorium
8:30 Opening of Exhibits: Milwaukee Auditorium
9:00 Reference Committees of the House of Delegates: Hotel Schroeder
9:30 Scientific Meetings on Obstetrics and Pediatrics: Milwaukee Auditorium

p.m.
12:30 Luncheons of Alumni Association of Marquette and U. of W. Medical Schools: Milwaukee Auditorium
12:30 Scientific Luncheons: Hotel Schroeder
2:00 Scientific Programs on Obstetrics and Pediatrics: Milwaukee Auditorium
4:00 Wisconsin Academy of General Practice, Conference and Dinner: Hotel Schroeder
5:30 Auxiliary Board of Directors Meeting: Hotel Schroeder
5:30 Special Dinner, Pediatricians and Wives: University Club, Milwaukee
7:30 Second Session of House of Delegates: Hotel Schroeder
8:00 Special Meeting on Internal Medicine: Hotel Schroeder

TUESDAY, MAY 12

a.m.
8:00 Registration and Opening of Exhibits: Milwaukee Auditorium
9:00 Third Session of House of Delegates: Hotel Schroeder
9:00 Scientific Program on "Medical Genetics": Milwaukee Auditorium (Cooperative program of Pathologists and Internists)
10:00 Business Meeting of Auxiliary: Hotel Schroeder
10:30 Meeting of the Council: Hotel Schroeder

p.m.
12:30 Scientific Luncheons: Hotel Schroeder
12:30 CES Foundation Officers and Trustees Luncheon and Annual Meeting: Hotel Schroeder
1:00 Auxiliary Luncheon: Milwaukee Athletic Club
2:00 Continuation of Scientific Program on "Medical Genetics": Milwaukee Auditorium
3:00 Wisconsin Society of Pathologists, Board Meeting: Hotel Schroeder
6:30 President's Reception (For those attending Dinner): Hotel Schroeder
7:15 Annual Dinner: Hotel Schroeder

WEDNESDAY, MAY 13

a.m.
8:30 Registration and Exhibits: Milwaukee Auditorium
9:30 Scientific Programs on Dermatology and Orthopedic Surgery: Milwaukee Auditorium
10:00 Auxiliary Business Meeting: Hotel Schroeder

(continued next column)

TIMETABLE continued

p.m.
12:30 Scientific Luncheons: Hotel Schroeder
12:00 Clinic Managers Luncheon, Milwaukee Athletic Club
12:30 Luncheon, Business Meeting and Scientific Program: Section on Ophthalmology & Otolaryngology: Milwaukee Auditorium
12:30 Past President's Luncheon: Hotel Schroeder
1:00 Auxiliary Luncheon: Stoeffers Restaurant, Top of Marine
2:00 Scientific Programs on Anesthesiology, EENT, Radiology, and Surgery: Milwaukee Auditorium
3:45 Close of Exhibits: Milwaukee Auditorium
5:00 Joint Dinner of Milwaukee Oto-Ophthalmic Society and Wisconsin Otolaryngological Society: University Club, Milwaukee
6:00 Dinner of Wisconsin Society of Anesthesiologists (and wives): Milwaukee Inn, Milwaukee
6:00 Dinner of Wisconsin Orthopedic Society (members only): Milwaukee Athletic Club
7:00 Dinner of Wisconsin Radiological Society Members (members and guests only): University Club, Milwaukee
7:00 Dinner of Wisconsin Surgical Society (and wives): Milwaukee Athletic Club

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time Monday, 8:00 a.m.–4:30 p.m.; Tuesday, 8:00 a.m.–4:00 p.m.; and Wednesday, 8:30 a.m.–3.30 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Senior and junior medical students will be admitted on Tuesday and Wednesday, May 12–13. Medical assistants and hospital personnel will be admitted on Wednesday, May 13 only, after 11:00 a.m. Interns and residents will be admitted without registration fee, any time during meeting, *if certified by hospital.* Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies will be admitted by membership cards.

★ **VA and M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

BEFORE LEAVING FOR MEETING

Give Your Secretary This Information

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—271–9609. For *Milwaukee MDs, Direct call through 273–7700, Ext. 200, and it will be relayed to a special phone near the main meeting hall at the Auditorium.* For those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—271–7250. Tell your secretary the room number of the luncheon, so we can locate you!

PRESS and STAFF ROOM
Room 509
HOTEL SCHROEDER

10:00—*Endocrine Aspects of Reproductive Failure*

ELEANOR DELFS, M.D., Milwaukee, Professor of Gynecology and Obstetrics, Marquette University School of Medicine, Milwaukee

10:30—RECESS TO VIEW EXHIBITS

Special Note: Those particularly interested in obstetrics will wish to study the special demonstration on TRANSVAGINAL PUDENDAL NERVE BLOCK conducted for the Division on Maternal and Child Welfare by members of the Wisconsin Society of Obstetrics and Gynecology and the Wisconsin Society of Anesthesiologists. These demonstrations are conducted from 10:00–12:00 noon and 2:00–4:00 p.m. on Monday and Tuesday, and from 10:00–12:00 noon and 2:00–3:45 p.m. on Wednesday. Booths 8–9 in the Exhibit Hall.

11:15—*Panel: Spontaneous Abortion and Premature Labor*

Moderator: William Kiekhofer, M.D., Madison

ELEANOR DELFS, M.D., Milwaukee

SPRAGUE H. GARDINER, M.D., Indianapolis, Ind.

RICHARD W. STANDER, M.D., Indianapolis, Ind.

II. SPECIAL PROGRAM ON PEDIATRICS: *MALIGNANCY IN CHILDREN*

KILBOURN HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Chapter of the American Academy of Pediatrics, with support from the American Cancer Society, Milwaukee and Wisconsin Divisions)

Chairman: TIBOR GREENWALT, M.D., Milwaukee

9:30—*Leukemia and its Relationship to Genetics*

WAYNE H. BORGES, M.D., Chief of Division on Hematology, Children's Memorial Hospital, Chicago, Ill.

10:00—Discussant: SAMUEL R. MC CREADIE, M.D., Milwaukee

10:15—Discussion from the AUDIENCE

10:30—RECESS TO VIEW EXHIBITS

11:15—*Panel: Leukemia and Other Malignant Hematologic Disorders in Children*

(Cases by Staff of Children's Hospital, Milwaukee)

Moderator: Tibor J. Greenwalt, M.D., Milwaukee

WAYNE H. BORGES, M.D., Chicago, Ill.

SAMUEL R. MC CREADIE, M.D., Milwaukee

ANTHONY V. PISCIOTTA, M.D., Milwaukee

R. W. Stander, M.D.

W. H. Borges, M.D.

P.M.

12:30 to 1:45—LUNCHEONS

12:30—AT MILWAUKEE AUDITORIUM

1. UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ALUMNI ASSOCIATION

   Juneau Hall of Milwaukee Auditorium

   Cost of luncheon: $4.00, including cocktails and service

   Make reservations direct to Mr. Ralph Hawley, 418 North Randall Avenue, Madison 6, Wis. Make check payable to U. of W. Medical School Alumni Association. Speaker to be announced

2. MARQUETTE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION

   Market Hall of Milwaukee Auditorium

   Cost of Luncheon: $2.50, including service.

   Make reservations direct to Marquette University Alumni Assn., 1834 West Wisconsin Ave., Milwaukee, Wis. 53233

12:30—AT HOTEL SCHROEDER

(All luncheons open to members of State Medical Society so long as places available. Seating limited, so advance reservations suggested)

PEDIATRIC LUNCHEONS

1. ***The Ironic Reticulocyte***

   WAYNE H. BORGES, M.D., Chief, Division of Hematology, Children's Memorial Hospital, Chicago, Ill.

   Chairman: Frank Stiles, M.D., Monroe

   English Room—5th Floor

2. ***Surgical Emergencies in the Newborn***

   E. THOMAS BOLES, JR., M.D., Assistant Professor of Surgery, Ohio State University College of Medicine, Columbus, O.

   Chairman: William Bartlett, M.D., Madison

   Room 507—5th Floor

OB & GYN LUNCHEONS

3. *The Obstetrician and Prematurity*

SPRAGUE H. GARDINER, M.D., *Professor of Obstetrics and Gynecology, University of Indiana Medical Center, Indianapolis, Ind.*

Chairman: W. A. Kretzschmar, M.D., Milwaukee

East Room—5th Floor

4. *Antenatal Prediction of Erythroblastosis Fetalis*

RICHARD W. STANDER, M.D., *Associate Professor of Obstetrics and Gynecology, University of Indiana Medical Center, Indianapolis, Ind.*

Chairman: Jack Klieger, M.D., Milwaukee

Pere Marquette Room—5th Floor

2:00—CONTINUATION OF SPECIAL PROGRAMS ON OBSTETRICS AND GYNECOLOGY, AND PEDIATRICS

I. SPECIAL PROGRAM ON *PREGNANCY WASTAGE*

PLANKINTON HALL—MILWAUKEE AUDITORIUM

Chairman: F. JACKSON STODDARD, M.D., Milwaukee

2:00—*Psychiatric Aspects of Abortion*

SPRAGUE H. GARDINER, M.D., *Professor of Obstetrics and Gynecology, University of Indiana Medical Center, Indianapolis*

2:30—*(Speaker to be Announced)*

3:00—RECESS TO VIEW EXHIBITS

3:45—*Business Meeting*

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY *(Members Only)*

II. SPECIAL PROGRAM ON *MALIGNANCY IN CHILDREN*

KILBOURN HALL—MILWAUKEE AUDITORIUM

Chairman: STEWART L. GRIGGS, M.D., Green Bay

E. T. Boles, Jr., M.D.

D. Y. Hsia, M.D.

2:00—*Abdominal Masses in Infants and Children*

E. THOMAS BOLES, JR., M.D., *Assistant Professor of Surgery, Ohio State University College of Medicine, Columbus*

2:30—Discussant: JOHN R. PELLETT, M.D., Madison

2:45—Discussion by the AUDIENCE

3:00—RECESS TO VIEW EXHIBITS

3:45—*Panel: Therapy of Malignant Tumors in Children*

(Cases provided by Department of Surgery, University of Wisconsin Medical School)

Moderator: John T. Pellett, M.D., Madison

E. THOMAS BOLES, JR., M.D., Columbus, O.

DONALD BABBITT, M.D., Milwaukee

SAMUEL R. MC CREADIE, M.D., Milwaukee

(Special note to members of the Wisconsin Chapter of the American Academy of Pediatrics: You and your wife are invited to a special dinner at the University Club, honoring A. B. SCHWARTZ, M.D., Milwaukee. See details on page 177.)

8:00—SPECIAL EVENING SCIENTIFIC PROGRAM

HOTEL SCHROEDER—East Room, 5th Floor

(Program of the Wisconsin Society of Internal Medicine, with support from the Wisconsin Heart Association; planned in cooperation with the Departments of Medicine at Marquette University School of Medicine and the University of Wisconsin Medical School)

Chairman: WILLIAM L. COFFEY, JR., M.D., Milwaukee, President of the Wisconsin Society of Internal Medicine

(Each paper 12 to 15 minutes. Remainder of time for questions.)

8:00—*Use of Chromium 51-Tagged Platelets in Thrombocytopenic States*

RICHARD D. SOLOMAN, M.D., Fellow in Hematology, University of Wisconsin Medical School, Madison

8:15—*Unusual Examples of Malabsorption*

WALTER J. HOGAN, M.D., Fellow in Gastroenterology, Department of Medicine, Marquette University School of Medicine, Milwaukee

8:30—*Catechol Amines Excretion with Vasovagel Syncope Associated with Blood Donation*

LOUIS CHOSY, M.D., Department of Internal Medicine, University of Wisconsin Medical School, Madison

8:45—*Pressor Amine Dependence Following Hypotensive States*

JAMES P. BOTTICELLI, M.D., Advanced American Heart Fellow, Department of Medicine, Marquette University School of Medicine, Milwaukee

9:00—*Hemodynamic Actions of Monamine Oxidase Antagonist*

DAVID McKENNA, M.D., Department of Internal Medicine, University of Wisconsin Medical School, Madison

9:15—*Drug Induced Hemolytic Anemia*

DAVID W. WESTRING, M.D., Fellow in Hematology, Department of Medicine, Marquette University School of Medicine, Milwaukee

9:30—*Polycythemia Vera Succeeding Myelogenous Leukemia*

DAVID DUFFY, M.D., Resident in Medicine, University Hospitals, Madison

Tuesday, May 12

A.M.

8:30—REGISTRATION

MILWAUKEE AUDITORIUM, Kilbourn Street Entrance

8:30—EXHIBITS OPEN

BRUCE HALL—MILWAUKEE AUDITORIUM

9:00—SPECIAL PROGRAM ON *MEDICAL GENETICS: A CLINICAL FIELD*

PLANKINTON HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Society of Pathologists and the Wisconsin Society of Internal Medicine)

Chairman: SAMUEL R. MC CREADIE, M.D., Milwaukee

9:00—*What is Medical Genetics?*

JAMES F. CROW, Ph.D., Professor of Medical Genetics, and Acting Dean, University of Wisconsin Medical School, Madison

9:30—*DNA Metabolism and Its Influence on Protein Synthesis*

CHARLES HEIDELBERGER, Ph.D., Professor of Oncology, University of Wisconsin Medical School, Madison

10:00—RECESS TO VIEW EXHIBITS

11:10—*Mechanics of Chromosome Analysis*

STANLEY INHORN, M.D., Assistant Professor of Preventive Medicine, University of Wisconsin Medical School, and Assistant Director, State Laboratory of Hygiene, Madison

11:30—*Panel: Content of Morning Lectures*

Moderator: DAVID YI-YUNG HSIA, M.D., Professor of Pediatrics, Northwestern University School of Medicine, Chicago, Ill.

JAMES F. CROW, Ph.D., Madison
CHARLES HEIDELBERGER, Ph.D., Madison
STANLEY INHORN, M.D., Madison
ARNO G. MOTULSKY, M.D., Seattle, Wash.

P.M.

12:30 to 1:45—LUNCHEONS

12:30—AT HOTEL SCHROEDER

(All luncheons open to members of State Medical Society so long as places available. Seating limited, so advance reservations suggested)

INTERNAL MEDICINE LUNCHEONS

1. *Recent Advances in Therapy*

OVID O. MEYER, M.D., Madison
Room 507—5th Floor

2. *Clinical Applications of Medical Genetics*

ARNO G. MOTULSKY, M.D., Seattle Wash.
Chairman: W. L. Coffey, Jr., M.D., Milwaukee
East Room—5th Floor

PATHOLOGY LUNCHEON

3. *Jaundice in the Newborn Infant*

DAVID YI-YUNG HSIA, M.D., Chicago, Ill.
Chairman: Robert S. Haukohl, M.D., Milwaukee
Pere Marquette Room—5th Floor

PSYCHIATRY LUNCHEON

4. *Maintenance Therapy with Psychotropic Drugs*

BURTRUM C. SCHIELE, M.D., Minneapolis, Minn.
Chairman: Keith Keane, M.D., Appleton
English Room—5th Floor

SURGICAL LUNCHEON

5. *Resume of Controversial Aspects of Breast Surgery*

ROBERT C. HICKEY, M.D., Professor and Chairman, Department of Surgery, University of Wisconsin Medical School, Madison
Room 508—5th Floor

NON-SCIENTIFIC LUNCHEON

6. *CES Foundation Officers and Trustees Annual Meeting*

Club Rooms—3rd Floor

(Those who are to attend this luncheon do so as guests of the Foundation, and need not send a payment to cover the cost of the luncheon.)

2:00—CONTINUATION OF PROGRAM ON *MEDICAL GENETICS* AND A SPECIAL PROGRAM ON *PSYCHIATRY*

I. MEDICAL GENETICS: A CLINICAL FIELD

(Continuation of morning program)

PLANKINTON HALL—MILWAUKEE AUDITORIUM

Chairman: JAMES W. MANIER, M.D., Marshfield

2:00—*Inborn Errors of Metabolism*

DAVID YI-YUNG HSIA, M.D., Professor of Pediatrics, Northwestern University School of Medicine, Chicago, Ill.

(William Beaumont Memorial Lecture of the CES Foundation)

2:30—*Hemoglobin Abnormalities*

ARNO G. MOTULSKY, M.D., Professor of Medicine and Genetics, University of Washington School of Medicine, Seattle, Wash.

3:00—RECESS TO VIEW EXHIBITS

3:45—*Question Period Based on Lectures of Afternoon Speakers*

DAVID YI-YUNG HSIA, M.D., Chicago, Ill.

ARNO G. MOTULSKY, M.D., Seattle, Wash.

II. SPECIAL PROGRAM ON *ANTI-DEPRESSANT DRUGS AND TRANQUILIZERS*

KILBOURN HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Psychiatric Association)

Chairman: KEITH M. KEANE, M.D., Appleton, President of the Wisconsin Psychiatric Association

2:00—*Current Perspectives on Anti-depressant Drugs*

BURTRUM C. SCHIELE, M.D., Professor of Psychiatry, University of Minnesota Medical School, Minneapolis, Minn.

(Rogers Memorial Lecture of the Rogers Memorial Hospital, Oconomowoc)

2:45—Discussant: WILLIAM HEYWOOD, M.D., Marshfield

3:00—RECESS TO VIEW EXHIBITS

B. C. Schiele, M.D.

A. G. Motulsky, M.D.

3:45—*Panel: Office and Hospital Use of Tranquilizing Drugs*

Moderator: Milton Miller, M.D., Madison

EARL JOCHIMSEN, M.D., Sheboygan
WILLIAM L. LORTON, M.D., Wauwatosa
GILBERT TYBRING, M.D., Madison
ROBERT URBANEK, M.D., Beaver Dam

7:15—ANNUAL DINNER OF THE STATE MEDICAL SOCIETY

HOTEL SCHROEDER

Speaker: F. J. L. BLASINGAME, M.D., Executive Vice-president of the American Medical Association, Chicago, Ill. Topic: "Of Tomorrow"

(See details on page 177)

Wednesday, May 13

A.M.

8:30—REGISTRATION

MILWAUKEE AUDITORIUM, Kilbourn Street Entrance

8:30—EXHIBITS OPEN

BRUCE HALL—MILWAUKEE AUDITORIUM

9:30—SPECIAL PROGRAMS ON OCCUPATIONAL DERMATOSIS AND FRACTURES OF THE KNEE AND ANKLE JOINTS

I. SPECIAL PROGRAM ON OCCUPATIONAL DERMATOSES

JUNEAU HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Dermatological Society)

continued on page 178

Special Dinners

MONDAY, MAY 11

WISCONSIN CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
5:30 p.m.

Special dinner honoring A. B. SCHWARTZ, M.D., Milwaukee, at the University Club, Milwaukee. *All pediatricians and their wives are invited to attend.* $5.50 per person. Reservations to Harry A. Waisman, M.D., Kennedy Laboratories, 1300 University Ave., Madison 6, Wis.

WEDNESDAY, MAY 13

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS
6:00 p.m.

Dinner and informal social gathering of members and wives, Milwaukee Inn, Milwaukee. $7.00 per person. Reservations to Sherman Myers, M.D., 645 Crystal Lane, Elm Grove, Wis.

WISCONSIN ORTHOPEDIC SOCIETY
6:00 p.m.

Dinner at the Milwaukee Athletic Club, members only —no wives! No charge for members, but reservations requested. Speaker: HARRY B. HALL, M.D., Minneapolis, Minn. Topic: Wedge Osteotomy of the Neck of the Femur for Treatment of Severe Slipping of a Femoral Capital Epiphysis. Reservations to Louis Kagen, M.D., 949 North 12th Street, Milwaukee, Wis. 53203.

Joint Meeting and Dinner
MILWAUKEE OTO-OPHTHALMIC SOCIETY
and
WISCONSIN OTOLARYNGOLOGICAL SOCIETY
(All members of the State Medical Society Section of Ophthalmology and Otolaryngology are invited to attend)

UNIVERSITY CLUB

5:00 p.m.—Speaker: JEROME A. HILGER, M.D., St. Paul, Minn. Topic: Grafts in Tymanomastoid Surgery.

6:00 p.m.—Cocktails (sponsored)

7:00 p.m.—Dinner. $6.00. Reservations must be made before May 1. Send check to Herbert Giller, M.D., 2040 W. Wisconsin Ave., Room 401, Milwaukee, Wis.

8:00 p.m.—Speaker: PAUL A. CHANDLER, M.D., Boston, Mass. Topic: Choice of Treatment in Angle Closure Glaucoma.

WISCONSIN RADIOLOGICAL SOCIETY
7:00 p.m.

Dinner at the University Club. For members, guests, and guest residents only—no wives! Speaker: ISADORE LAMPE, M.D., Ann Arbor, Mich. Topic: The Impact of High Energy Radiation on Radiotherapy. $5.00 per person—no charge for radiology residents with member. Please indicate if you are bringing a resident with you. Reservations to Robert W. Byrne, M.D., Columbia Hospital, Milwaukee 11, Wis.

WISCONSIN SURGICAL SOCIETY
7:00 p.m.

Informal dinner at the Milwaukee Athletic Club for members, wives, and guests only; Norman O. Becker, M.D., presiding. Speaker: ROBERT T. TIDRICK, M.D., Iowa City, Ia. Topic: Primitive Surgery in the Midlands. Tickets may be purchased at noon on day of meeting of Surgical Society at Mt. Sinai Hospital.

Annual Dinner

TUESDAY EVENING
MAY 12

GUEST SPEAKER

F. J. L. Blasingame, M. D.

EXECUTIVE VICE-PRESIDENT
AMERICAN MEDICAL ASSOCIATION

Topic: "Of Tomorrow"

President's Reception
6:30 P.M.

Annual Dinner
7:15 P.M.

Presentation of Fifty-Year Club Awards

Dancing to the Music of the Executives

MAIL YOUR ADVANCE REGISTRATION TODAY

See page 186

D. J. Birmingham, M.D.

Evan Fredericksan, M.D.

9:30—*Case Studies and Discussion from the Viewpoint of Parties Most Concerned*

(Cases furnished by Milwaukee dermatologists, and as each case is presented it will be discussed from the viewpoint of the parties on the panel. In each case there will be opportunity for questions and comments from the audience.)

Chairman: STURE A. M. JOHNSON, M.D., Professor of Dermatology, University of Wisconsin Medical School, Madison

DONALD J. BIRMINGHAM, M.D., Associate Clinical Professor of Dermatology, University of Cincinnati College of Medicine, Cincinnati, O.
(From the viewpoint of the MD and Public Health)

MR. J. R. LEFFLER, Employers Mutual, Wausau

MR. DAVID PARISH, Hardware Mutuals, Madison
(From the viewpoint of the Insurance Carrier)

MR. LAWRENCE GILLICK, Milwaukee
(From the viewpoint of the Lawyer)

MR. DONALD ZWIRLEIN, Cutler–Hammer Co., Milwaukee
(From the viewpoint of the Safety Engineer)

MR. NORMAN J. TAUGHER, Madison
(From the viewpoint of the Wisconsin Industrial Commission)

10:30—RECESS TO VIEW EXHIBITS

11:15—CONTINUATION OF CASE PRESENTATIONS AND DISCUSSION

II. SPECIAL PROGRAM ON *FRACTURES OF THE KNEE AND ANKLE JOINTS*

KILBOURN HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Society of Orthopedic Surgeons)

Chairman: PAUL J. COLLOPY, M.D., Milwaukee, President, Wisconsin Society of Orthopedic Surgery

9:30—*Fractures About the Knee Joint*

HARRY B. HALL, M.D., Clinical Professor of Orthopedic Surgery, University of Minnesota Medical School, Minneapolis, Minn.

10:30—RECESS TO VIEW EXHIBITS

11:15—*Panel: Treatment of Fractures about the Ankle Joint*

Moderator: Paul J. Collopy, M.D., Milwaukee

HARRY B. HALL, M.D., Minneapolis, Minn.
CHESTER SATTLER, M.D., Kenosha
HERMAN W. WIRKA, M.D., Madison

(Special note to members of the Wisconsin Society of Orthopedic Surgery: You are reminded of the special dinner—members only, not wives—at the Milwaukee Athletic Club, with Doctor Hall as speaker. See details on page 177.)

P.M.

12:30 to 1:45—LUNCHEONS

12:30—AT HOTEL SCHROEDER

(All luncheons open to members of State Medical Society so long as places available. Seating limited, so advance reservations suggested)

ANESTHESIA LUNCHEONS

1. *The Development of Atelectasis During Anesthesia*

DOUGLAS W. EASTWOOD, M.D., Professor of Anesthesiology and Chairman of the Department, University of Virginia School of Medicine, Charlottesville, Va.

Chairman: Robert E. Holzgrafe, M.D., Milwaukee

English Room—5th Floor

2. *Clinical Hypotension with Halothane*

EVAN FREDERICKSON, M.D., Professor of Anesthesiology, University of Kansas School of Medicine, Kansas City, Kan.

Chairman: David J. Noll, M.D., Madison

Room 507—5th Floor

DERMATOLOGY LUNCHEON

3. *Use and Misuse of the Patch Test in the Diagnosis of Occupational Skin Disease*

DONALD J. BIRMINGHAM, M.D., Associate Clinical Professor of Dermatology, University of Cincinnati College of Medicine, Cincinnati, O.

Chairman: Daniel E. Hackbarth, M.D., Milwaukee

Room 508—5th Floor

ORTHOPEDIC SURGERY LUNCHEON

4. *The Flexion and Extension Injuries to the Neck Following a Rear-end Auto Collision*

HARRY B. HALL, M.D., Clinical Professor of Orthopedic Surgery, University of Minnesota Medical School, Minneapolis, Minn.

Chairman: John O. McCabe, M.D., Milwaukee

Pere Marquette Room—5th Floor

PHARMACOLOGY AND INTERNAL MEDICINE LUNCHEON

5. *New Concepts in the Drug Therapy of Angina Pectoris*

HAROLD F. HARDMAN, M.D., Ph.D., Professor and Chairman, Department of Pharmacology, Marquette University School of Medicine, Milwaukee

Parlor A—4th Floor

PUBLIC HEALTH LUNCHEON

6. *Medical Genetics as a Public Health Problem*

JAMES F. CROW, Ph.D., Professor of Medical Genetics and Acting Dean, University of Wisconsin Medical School, Madison

Chairman: E. R. Krumbiegel, M.D., Milwaukee

Parlor D—4th Floor

RADIOLOGY LUNCHEON

7. *Radiologic Aspects of Acute Gastrointestinal Hemorrhage*

BUELL C. BUCHTEL, M.D., Head of the Department of Radiology, Ochsner Clinic, New Orleans, La.

Chairman: Howard G. Bayley, M.D., Beaver Dam

East Room—5th Floor

NON-SCIENTIFIC LUNCHEON

8. *For Past Presidents of the State Medical Society*

(Only past presidents and special guests to be in attendance. All guests of the Society, so if you are to attend, do not include the cost of this luncheon in your reservation.)

Parlor G—5th Floor

12:30—AT MILWAUKEE AUDITORIUM

SPECIAL E.E.N.T. LUNCHEON

All physicians attending the special program on Ophthalmology and Otolaryngology are requested to make an advance reservation for the luncheon. Special guests will be PAUL A. CHANDLER, M.D., Boston, Mass., and JEROME A. HILGER, M.D., St. Paul, Minn., who will address the group following luncheon and the business session of the Section. Luncheon in COMMITTEE ROOM 1 of the SPORTS ARENA, Milwaukee Auditorium. Those attending enter through the exhibits in Bruce Hall, and then turn right into the entrance to the Sports Arena.

Price of luncheon: $2.50, including service.

(Also see page 177 for special dinner meeting of Milwaukee Oto-ophthalmic Society and Wisconsin Otolaryngological Society. All E.E.N.T. physicians and specialists within field of E.E.N.T. are urged to attend.)

2:00—SPECIAL TEACHING PROGRAMS IN *ANESTHESIA, E.E.N.T., RADIOLOGY, AND SURGERY*

I. SPECIAL PROGRAM ON *ANESTHESIOLOGY*

JUNEAU HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Society of Anesthesiologists)

Chairman: DAVID J. NOLL, M.D., Madison, President, Wisconsin Society of Anesthesiologists

2:00—*Some Aspects of Nitrous Oxide Pharmacology and Toxicity Affecting Clinical Use*

DOUGLAS W. EASTWOOD, M.D., Professor of Anesthesiology, University of Virginia Hospital, Charlottesville, Va.

2:30—*Notes on the Production of Analgesia with Nitrous Oxide*

EVAN FREDERICKSON, M.D., Professor of Anesthesiology, University of Kansas School of Medicine, Kansas City, Kan.

3:00—RECESS TO VIEW EXHIBITS

3:45—*Panel: The Current Use of Halothane—Pros and Cons*

Moderator: David J. Noll, M.D., Madison

D. W. EASTWOOD, M.D., Charlottesville, Va.
EVAN FREDERICKSON, M.D., Kansas City, Kan.
JAY J. JACOBY, M.D., Milwaukee
BETTY BAMFORTH, M.D., Madison

(Special note to members of the Wisconsin Society of Anesthesiologists: You are reminded of the informal dinner—no speeches—for members and wives, at the Milwaukee Inn, starting at 6:00 p.m. See details on page 177.)

II. SPECIAL PROGRAM ON *OPHTHALMOLOGY AND OTOLARYNGOLOGY*

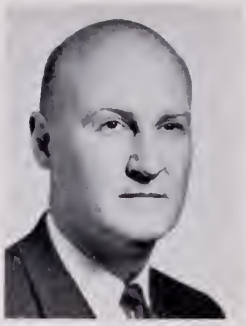
COMMITTEE ROOM 1—SPORTS ARENA, Milwaukee Auditorium

(To reach Committee Room 1 go through Exhibit area in Bruce Hall, turn right to entrance of Sports Arena and follow signs.)

(Program planned in cooperation with the State Medical Society Section on Ophthalmology and Otolaryngology, the Milwaukee Oto-ophthalmic Society, and the Wisconsin Otolaryngological Society)

Chairman: SAMUEL S. BLANKSTEIN, M.D., Milwaukee, President of the Section on Ophthalmology and Otolaryngology

D. W. Eastwood, M.D.



J. A. Hilger, M.D.

P. A. Chandler, M.D.

B. C. Buchtel, M.D.

Wednesday — continued

12:30—SPECIAL E.E.N.T. LUNCHEON (See details above)

1:00—BUSINESS MEETING OF SECTION

2:00—*Mid-facial Injuries*

JEROME A. HILGER, M.D., Clinical Professor of Otology, University of Minnesota Medical School, Minneapolis, Minn.

(Sponsored by the Wisconsin Otolaryngological Society)

2:45—DISCUSSION AND QUESTIONS

3:00—RECESS TO VIEW EXHIBITS

3:45—*Choice of Treatment in Dislocation of the Lens*

PAUL A. CHANDLER, M.D., Associate Clinical Professor of Ophthalmology, Harvard Medical School, Boston, Mass.

(Sponsored by the Milwaukee Oto-ophthalmic Society)

4:15—DISCUSSION AND QUESTIONS

III. SPECIAL PROGRAM ON *RADIOLOGY*

KILBOURN HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Radiological Society)

Chairman: HOWARD G. BAYLEY, M.D., Beaver Dam

2:00—*Spondylolisthesis and Spondylolysis Are Not Congenital*

ABRAHAM MELAMED, M.D., Milwaukee

2:15—*Renal Vein Thrombosis*

JOSEPH BERES, M.D., FRANK ZBORALSKE, M.D., JOHN AMBERG, M.D., and STUART WILSON, M.D., Milwaukee

(Presented by John Amberg, M.D., Milwaukee)

2:30—*Radiological Evaluation of Hypertension of Renal Origin*

BUELL C. BUCHTEL, M.D., Head of the Department of Radiology, Ochsner Clinic, New Orleans, La.

3:00—RECESS TO VIEW EXHIBITS

3:45—*The Role of Radiotherapy in the Treatment of Cancer*

ISADORE LAMPE, M.D., Professor of Radiology, University of Michigan Medical School, Ann Arbor, Mich.

4:15—*The Role of Chemical Adjuvants in Radiotherapy*

HALVOR VERMUND, M.D., and FRANK F. GOLLIN, M.D., Madison

(Presented by Frank F. Gollin, M.D., Madison)

4:30—*Business Meeting*

SECTION ON RADIOLOGY, STATE MEDICAL SOCIETY

4:45—*Board of Directors Meeting*

WISCONSIN RADIOLOGICAL SOCIETY

(Special note to members of the Wisconsin Radiological Society: You are reminded that there will be a special dinner for members and guests only—no wives—at the University Club, Milwaukee, beginning at 7:00 p.m. Doctor Lampe will speak. See details on page 177.)

IV. SPECIAL PROGRAM ON *SURGERY*

PLANKINTON HALL—MILWAUKEE AUDITORIUM

(Program planned in cooperation with the Wisconsin Surgical Society)

Chairman: MORRISON SCHROEDER, M.D., Milwaukee, President of the Wisconsin Surgical Society

Isodore Lampe, M.D.

R. T. Tidrick, M.D.

2:00—*Islet Cell Tumors of the Pancreas with Hyperinsulinism*

KENNETH E. LEMMER, M.D., Professor, Department of Surgery, University of Wisconsin Medical School, Madison

2:15—*Alterations of Cardiovascular and Pulmonary Function Due to Surgical Positions*

ERNEST O. HENSCHEL, M.D., Chief of Anesthesiology Section, VA Hospital, Wood (Milwaukee)

2:30—*Patient and Doctor Responsibility for Service in the Emergency Room*

FREDERICK BUNKFELDT, JR., M.D., Milwaukee

2:45—*A Comparative Study of Current Methods of Treatment of Carcinoma of the Breast*

(Address of the Incoming President)

NORMAN O. BECKER, M.D., Fond du Lac

3:00—INTERMISSION

3:20—*Surgical Treatment of Chronic Ulcerative Colitis*

JOSEPH J. GRAMLING, JR., M.D., Milwaukee

3:35—*Prognosis and Treatment of Peripheral Vascular Malformations*

ROBERT T. TIDRICK, M.D., Professor of Surgery and Head of the Department, State University of Iowa College of Medicine, Iowa City, Ia.

4:05—*Business Meeting*

SECTION ON SURGERY, STATE MEDICAL SOCIETY

4:20—*Business Meeting*

WISCONSIN SURGICAL SOCIETY

(Special note to members of the Wisconsin Surgical Society: You are reminded that following the scientific program—and the business meeting of the Wisconsin Surgical Society—there will be a dinner for MEMBERS ONLY. Details from the Secretary of the Wisconsin Surgical Society.)

House of Delegates

Since the Annual Meeting Scientific Program has been set ahead one day (Monday-Tuesday-Wednesday instead of Tuesday-Wednesday-Thursday, as in past years), the House of Delegates meetings have also been set ahead one day. This year the House will meet Sunday night, May 10, Monday night, May 11, and Tuesday morning, May 12.

These meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session. Old business from October Interim Session will also be presented. Reference committees will meet Monday morning, with reports to be made at the Monday night, or second, session. Other business, including election of officers and councilors, will be held Tuesday morning, at the final session.

Society members are urged to participate in the discussions on reports, resolutions and nominations before the committees Tuesday morning. Reference committees will close their sessions at noon in order to prepare reports for the evening session of the House of Delegates.

SCHEDULE

SUNDAY, MAY 10

p.m.

6:00 BUFFET SUPPER for Delegates, Alternates and SMS Officers, Hotel Schroeder, Pere Marquette Room, 5th floor

6:30 REGISTRATION of the House of Delegates, Hotel Schroeder, 5th floor foyer

7:00 FIRST SESSION, House of Delegates, Hotel Schroeder, Crystal Ballroom, 5th floor

MONDAY, MAY 11

a.m.

9:00 REFERENCE COMMITTEE MEETINGS of the House of Delegates, Hotel Schroeder

COMMITTEE ON NOMINATIONS, Pine Room, 5th floor

COMMITTEE ON RESOLUTIONS and Amendments to the Constitution and Bylaws, Crystal Ballroom, 5th floor

COMMITTEE ON REPORTS OF OFFICERS, Room 507, 5th floor

COMMITTEE ON REPORTS OF STANDING COMMITTEES, Room 508, 5th floor

p.m.

7:30 SECOND SESSION, House of Delegates, Hotel Schroeder, Crystal Ballroom, 5th floor

TUESDAY, MAY 12

a.m.

9:00 THIRD SESSION, House of Delegates, Hotel Schroeder, Crystal Ballroom, 5th floor

Scientific Exhibits

MILWAUKEE AUDITORIUM

EXHIBIT HOURS

Monday, May 11 ..... 8:30 a.m.–5:00 p.m.
Tuesday, May 12 ..... 8:30 a.m.–5:00 p.m.
Wednesday, May 13 ..... 8:30 a.m.–3:45 p.m.
(Exhibits "break up" at 3:45 p.m. on Wed., May 13)

IN MAIN EXHIBIT HALL

S–2—VASCULAR EMERGENCIES OF THE KIDNEYS

Drs. K. E. SAUTER, J. F. WEPFER, and J. W. SARGENT, St. Joseph's Hospital, Milwaukee

Consists of pertinent x-rays including excretory urograms retrograde urograms, and in some instances, aortograms on a series of four or five patients, each of which exhibited a sudden vascular emergency, i.e., spontaneous renal hemorrhage, hamartoma, ruptured aortic aneurysm, and renal artery thrombosis. A legend with each case will describe briefly the age, symptoms, indications for surgery, and findings at surgery. Where available, colored slides of the pathology will also be demonstrated.

S–3—POWER LAWN MOWER INJURIES

Drs. J. T. SULLIVAN, Jr. and J. S. KRETCHMAN, St. Joseph's Hospital, Milwaukee

Statistics on the number of injuries due to power mowers will be presented, along with a summary of those injuries treated at St. Joseph's Hospital. Photographs and x-ray reproductions will be shown. Rules of safety for operating power mowers will be graphically pointed out with the use of a mural depicting a man operating a power mower under maximum conditions of negligence and error. The need for uniform coding of these injuries by hospital medical record departments and greater public education will be emphasized.

S–3—A STUDY OF UNDECALCIFIED RIB SECTIONS

Drs. C. H. HICKEY and JAMES BIANCHIN, and BRUCE HARTMAN (student), St. Joseph's Hospital, Milwaukee

A number of photomicrographs demonstrating the normal microscopic anatomy of bone in various age groups and some abnormalities of bone, particularly those involving disturbance of bone deposition or replacement will be shown. Forty to 50 microns thick undecalcified rib cross sections will be used.

S–5—RECOGNITION OF INDUSTRIAL DERMATITIS

Drs. ROGER LAUBENHEIMER and F. H. URBAN, Evangelical Deaconess Hospital, Milwaukee

Various types of industrial skin disease will be presented with pictures and text by region along with differential diagnosis.

S–6—DIFFERENTIAL CHEMOTHERAPY PERFUSION IN TREATMENT OF BRONCHOGENIC CARCINOMA

Drs. A. H. PEMBERTON, B. G. NARODICK and J. D. HURLEY, Evangelical Deaconess Hospital, Milwaukee

A perfusion technique is demonstrated utilizing extracorporeal circulation which permits delivery of high concentrations of anti-cancer drugs to tumor bearing areas in patients with inoperable carcinoma of the lung and esophagus. The early and late results of treatment in over 50 patients will be described.

S–7—SPONDYLOLISTHESIS AND SPONDYLOLYSIS ARE NOT CONGENITAL

Drs. ABRAHAM MELAMED and J. H. JOHNSON, Evangelical Deaconess Hospital, Milwaukee

Several theories of etiology of spondylolysis have been advanced. Many observers believe spondylolysis and spondylolisthesis are congenital in origin, but accurate dissection studies of over 700 fetuses have failed to substantiate the congenital theory. This exhibit stresses the acquired etiology of defects in the pars interarticularis.

S–8–9—TRANSVAGINAL PUDENDAL NERVE BLOCK (Demonstrations)

Members of the Wisconsin Society of Anesthesiologists and the Wisconsin Society of Obstetrics and Gynecology, in cooperation with the Departments of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee, and the University of Wisconsin Medical School, Madison

This will consist of demonstrations, and audience participation, provided on a continuing basis from 10 a.m. to 12 n., and 2–4 p.m., Monday and Tuesday; and 10 a.m. to 12 n., and 2–3:45 p.m., Wednesday. All those who are in any manner concerned with the care of obstetrical patients are invited to attend these demonstrations and become proficient in the technique covered.

S–10–11—THE PATHOGENESIS OF BRONCHIECTASIS

Drs. W. W. STEAD and D. Y. ROSENZWEIG, Muirdale Sanatorium, Marquette University School of Medicine, Milwaukee County Hospital

Three panels will show x-ray films and photomicrographs to depict the role of necrotizing infections in the damage to bronchial walls which predisposes them to subsequent chronic suppurative infections. Cases of damage done by primary tuberculosis and necrotizing pneumonia are illustrated. There are three illuminated panels on which the legends of the case histories and the x-ray films and photomicrographs are shown.

S–12—INTRACAVITARY QUINACRINE INSTILLATION THERAPY OF MALIGNANT EFFUSIONS

Dr. JOHN MORLEDGE and Associates, Department of Internal Medicine, Jackson Clinic, Madison

The exhibit will display the history of investigative development of quinacrine (Atabrine) instillation therapy, brief tabular display of reported experience of others, and chemical structure of quinacrine. Color enlargement transparencies will display technique of intrapleural and intra-abdominal instillation of drug, and representative transparencies of chest films and abdomi-

nal color photographs, before and after therapy, will be displayed. Tabular summary of our own treatment results will be displayed.

S–13—CANCER OF THE HEAD AND NECK

Drs. R. C. HICKEY, MAXINE BENNETT, J. K. SCOTT, R. O. JOHNSON and HALVOR VERMUND, University of Wisconsin Medical Center, Madison

Information for the physician will be presented as to incidence of head and neck cancer, symptoms of lesions in this area, the importance of early correct diagnosis and aids in diagnostic technique, the modalities of therapy available (surgery, radiation, chemotherapy combined), and the availability of these services at the Head and Neck Tumor Clinic held every Monday afternoon, Bradley 2. Colored photographs of patients with representative lesions will be illustrated together with description of therapy.

S–14—HAND INJURIES

Dr. R. C. HICKEY, Hand Service of the Department of Surgery, University of Wisconsin Medical Center, Madison

This exhibit will illustrate the treatment of some of the commonly encountered hand injuries.

S–15—CONTRASTING RADIOTHERAPY FOR CANCER OF CERVIX

Departments of Gynecology and Radiotherapy, University of Wisconsin Medical School, Madison

The exhibit will portray differences in dosages of roentgen rays delivered by 250 KV machine and millionvolt x-ray (or teleotherapy Co^{60}); and difference in dosage when calculating intracavitary radiation as roentgens versus milligram hours.

S–16—PULMONARY BLASTOMYCOSIS SIMULATING CARCINOMA

Drs. JACOBO BARON and P. F. SCHATZKI, Mount Sinai Hospital, Milwaukee

Clinical findings and similarities between pulmonary blastomycosis and carcinoma including age, sex, symptoms and other observations will be pointed out. Three cases of blastomycosis and one case of carcinoma form the basis for comparison. Gross pathological aspects and microscopic features will be demonstrated including the tissue reaction and the appearance of the organism with regular and special stains. The appearance of the fungus in the sputum, mycological data including cultures and microscopic appearance of the fungus, and epidemiology with reference to Milwaukee and Wisconsin will be featured. Opportunity for preoperative diagnosis of pulmonary blastomycosis by sputum studies and/or bronchial washings will be indicated.

S–17—IN VITRO MEASUREMENT OF THYROID FUNCTION

Drs. D. J. CARLSON and D. J. LaFOND, and MTs. (ASCP) MARIE HEINEN and SUZANNE CARROLL, Milwaukee Hospital

The exhibit by photograph will outline procedure used in Resin-Sponge Tri-iodothyronine test (Triosorb)[R]. Three hundred and forty (340) determinations were performed in duplicate. Statistical analysis will demonstrate distribution studies, normal ranges and values, and standard deviation. Comparable data is available for I-131 and RBC-T3 and protein-bound iodine in one-third or more cases. Comparative studies (scatter-grams) will be shown comparing Resin-Sponge T3 values with values of the other procedures. A short summary of history of thyroid testing procedures will be shown. Indications and advantages of this procedure will also be given.

S–18–19—CONSERVE VISION BY DETECTING GLAUCOMA

Drs. L. L. GARNER, W. C. PARKS and E. E. GROSSMAN, Glaucoma Referral Center, Marquette University School of Medicine, and Neurological and Sensory Disease Service Bureau, Division Chronic Diseases, U. S. Public Health Service, Department of Health, Education and Welfare

A short course in the technique of tonometry will be made available to every physician interested in the use of the Schiotz tonometer for the detection of glaucoma. Instructors will demonstrate with mannequins the routine use of the tonometer and will permit each physician an opportunity to measure the intraocular pressure using this new medium of instruction.

S–20—RECONSTRUCTION OF THE MANDIBLE WITH BONE GRAFTS

Dr. R. P. GINGRASS, St. Joseph's Hospital, Milwaukee

This exhibit will consist of photographs and x-ray films of patients who had resection of the mandible for benign and malignant neoplasms followed by reconstruction of the mandible with iliac and rib grafts.

S–20A—VASOMOTOR HAND PROBLEMS IN INDUSTRY

Drs. J. E. CONLEY, R. B. PITTELKOW and G. L. MENDELOFF, Columbia Hospital, Milwaukee

Photographs and clinical notes on types of vasomotor problems of the hands arising from occupation will be presented. Included in the clinical presentation are examples of immersion and exposure syndromes, Raynaud's phenomenon, post-traumatic sympathetic dystrophy, and derangements from vibratory tools. Modes of treatment for specific problems are discussed.

S–20B—THE CONFIGURATION OF ABDOMINAL PARIETES

Drs. R. S. MONK, S. D. WILSON, L. C. CAREY, Marquette University School of Medicine, Milwaukee

The anatomical contour of the parietal peritoneum as demonstrated by molds of eviscerated cadavers will be displayed. The purpose is to demonstrate the anatomical relationship of the major peritoneal cavity with the pelvic cavity, encourage "complete" examination of the abdominal parietes as part of the routine in patients with an acute surgical abdomen, demonstrate the accurate contour of the abdominal parietes and attract attention to the inaccuracies perpetuated in textbook illustration, stress the importance of individualizing patients as to method of examination and interpretation of findings, and demonstrate the mold as an aid to teaching.

S–21–22–23—THE MILWAUKEE BRACE IN THE NONOPERATIVE TREATMENT OF SCOLIOSIS

Drs. W. P. BLOUNT and J. H. MOE, and R. G. BIDWELL, R. O., Marquette University, Milwaukee, and University of Minnesota, St. Paul

Eighteen varied cases of scoliosis in which the brace was used will be illustrated by transparencies of x-ray films and color photos. There is one plaster model of a torso with a removable brace, and a continuous projector of slides is supplied with taped narration depicting largely the method of manufacturing the brace. The case studies develop the selection of cases and the various modifications of treatment that are necessary for the individual types of scoliosis; end results are shown to prove that the present nonoperative treatment is permanently effective.

S–24—THE DIFFERENTIAL DIAGNOSIS OF TROPICAL DISEASE

Dr. W. F. SCHORR, Marshfield Clinic, Marshfield; and Dr. FRANCISCO KERDEL–VEGAS, Hospital Vargas, Caracas, Venezuela; Doctor Schorr, Nardo Zaias, Department of Dermatology, University of Miami

Shown will be color prints of yaws, leishmaniasis, leprosy, chromomycosis, South American blastomycosis, pinta, mycetoma and erythema dyschromicum perstans since these diseases simulate each other as well as nontropical disease.

S–25—NORMAL IVP'S IN THE PRESENCE OF VESICOURETERAL REFLUX

Dr. N. A. MOFFAT, Marshfield Clinic Foundation for Medical Research and Education, Marshfield

This exhibit is designed to emphasize the fact that normal intravenous urograms and significant reflux can occur in the same child at the same time. Where there is a history of recurrent urinary tract infections, persistent pyuria, repeated febrile illnesses without known cause, or voiding disturbances, a cystogram made before an intravenous urogram and preferably during voiding must be obtained. The absence of reflux may not be assumed from a normal intravenous urogram.

S–26—COMPACT SINGLE UNIT OXYGENATOR, HEAT EXCHANGER AND RESERVOIR FOR HYPOTHERMIC HEMODILUTION IN TOTAL BODY PERFUSION

Dr. R. D. SAUTTER, Marshfield Clinic, Marshfield

The exhibit will include the apparatus assembled and functioning with appropriate identifying labels, a disassembled model for close examination, a large diagram showing internal construction, a photograph showing how the entire oxygenator heat exchanger, debubbling cannister and reservoir can be sterilized as one unit, a photograph showing blood interphase in the reservoir, a table showing pertinent biochemical information concerning this apparatus—both dog and clinical studies, and a table showing efficiency of heat exchanger.

S–27–28—WISCONSIN SOCIETY OF PATHOLOGISTS

(1) Demonstrations of Gross Tissue Pathology

(2) CLINICAL PATHOLOGY—National Quality Control and Medical Technology as a Career

The 1964 exhibit by the Wisconsin Society of Pathologists will consist of two booths. One of these booths will be devoted to Anatomical Pathology and will feature a presentation of gross tissue pathology. The other booth, concerned with Clinical Pathology, will deal with National Quality Control of Clinical Laboratories and Medical Technology as a Career highlighting the Qualifications and Educational Program of the Medical Technologists as established by the American Society of Clinical Pathology.

EXHIBITS ON STAGE

S–29—PERHAPS YOU DIDN'T KNOW

Wisconsin Society for Medical Research

The exhibit will point up the efforts of antivivisectionists to dangerously interfere with medical research by sponsoring legislation which will hamper the use of animals in experimentation. The exhibit will also inform the public about the efforts of the Wisconsin Society for Medical Research to assure the humane but continued use of animals in medical and biological research.

S–30—CANCER REGISTRY IN HOSPITALS

American Cancer Society, Milwaukee and Wisconsin Divisions

S–31—

Wisconsin Anti-Tuberculosis Association

S–32—ARTHRITIS

Arthritis and Rheumatism, Foundation—Wisconsin Chapter

HALLWAY LEADING TO MEETING HALLS

S–37—THE HINGED-LEAFLET PROSTHETIC HEART VALVE

Drs. V. L. GOTT, J. D. WHIFFEN, D. E. KOEPKE and W. P. YOUNG; R. L. DAGGETT, M.A.M.E.; R. C. DUTTON, B.S.; Department of Surgery, University of Wisconsin Medical School, Madison, and the Wisconsin Heart Association

The exhibit will depict the development of the hinged-leaflet valve which has been developed at the University of Wisconsin Medical School. It consists of five sections. The first section will depict the development of the valve design and this will be portrayed on a wide moving belt. The second panel will depict the graphite coating which has significantly reduced the clotting on the valve. The third panel will contain a valve tester with valves moving to show the in vitro valve action. The fourth panel will relate the experience of 125 animals in the development of the valve through these experiments, and the last panel will show the clinical experience which consists of 15 patients to date.

S–38—LEUKOCYTE FILTER FOR PREPARING BUFFY LAYER-POOR BLOOD

Dr. T. J. GREENWALT, Milwaukee Blood Center, Inc., Milwaukee

A nylon fiber column for preparing buffy layer-poor blood is described. A summary of the pertinent hematologic data and clinical results with 608 pint units of blood processed with this equipment is presented.

Technical Exhibits

28—ABBOTT LABORATORIES, North Chicago, Ill.
64—AMES COMPANY, Elkhart, Ind.
21—ARMOUR PHARMACEUTICAL CO., Chicago, Ill.
70—ARNAR STONE LABORATORIES, INC., Mount Prospect, Ill.
29—AYERST LABORATORIES, Chicago, Ill.

B4—ROBERT W. BAIRD CO., Milwaukee
25—BEUTLICH, INC., Chicago, Ill.
59—BENCO OPHTHALMIC LABORATORIES, INC., Milwaukee
17—THE BORDEN COMPANY, New York City
16—BURROUGHS WELLCOME CO., Tuckahoe, N. Y.

61—CARNATION COMPANY, Los Angeles, Calif.
46—CIBA PHARMACEUTICAL CO., Summitt, N. J.
49—COCA-COLA BOTTLING COMPANY OF WISCONSIN, Milwaukee

88, 89—DANIELS SURGICAL & MEDICAL SUPPLIES, INC., Chicago, Ill.
87—THE DOYLE PHARMACEUTICAL COMPANY, Minneapolis, Minn.

51—EATON LABORATORIES, Norwich, N. Y.
85—ECONO LEASE OF MILWAUKEE, Milwaukee
76—THE EMKO COMPANY, St. Louis, Mo.
2—ENDO LABORATORIES, INC., Richmond Hill, N. Y.
33—MARSHALL ERDMAN & ASSOCIATES, Madison

73—A. J. FARNHAM COMPANY, INC., Milwaukee

38—GEIGY PHAMACEUTICALS, Yonkers, N. Y.
1—GENERAL ELECTRIC X-RAY, Milwaukee
22—GERBER PRODUCTS, Fremont, Mich.

B—HAUG DRUG COMPANY, Milwaukee
62—HOFFMANN–LA ROCHE, INC., Nutley, N. J.
67, 68—HURLEY X-RAY COMPANY, Milwaukee

14—KNOLL PHARMACEUTICAL COMPANY, Orange, N. J.
4—KREMERS–URBAN COMPANY, Milwaukee

9—LAKESIDE LABORATORIES, INC., Milwaukee
65, 66—LANGER LABORATORIES, Milwaukee
3—LEDERLE LABORATORIES, Pearl River, N. Y.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
44, 45—ELI LILLY & COMPANY, Indianapolis, Ind.
27—LOEWI & COMPANY, INC., Milwaukee
B6—LOV-E BRASSIERE COMPANY, Hollywood, Calif.

1B—McNEIL LABORATORIES, INC., Fort Washington, Pa.
30—MARION LABORATORIES, INC., Kansas City, Mo.
5B—MEAD JOHNSON LABORATORIES, Evansville, Ind.
47—MEDCO PRODUCTS COMPANY, INC., Tulsa, Okla.
43—MEDICAL PROTECTIVE CO., Fort Wayne, Ind.
19—MEDICO-MART, INC., Milwaukee
40, 41, 54, 55—MERCK SHARP & DOHME, West Point, Pa.
60—WM. S. MERRELL COMPANY, Cincinnati, O.
37—MID-WESTERN SPORT TOGS, Berlin
B0—C. V. MOSBY COMPANY, St. Louis, Mo.

52—NATIONAL DRUG COMPANY, Philadelphia, Pa.

13—ORTHO PHARMACEUTICAL CORP., Raritan, N. J.

56—PACIFIC MEDICAL EQUIPMENT CO., North Hollywood, Calif.
79—PARKE, DAVIS & CO., Detroit, Mich.
82—PENGELLY X-RAY CORP., Milwaukee
75—PFIZER LABORATORIES, New York City
31—PHYSICIANS & HOSPITALS SUPPLY CO., Minneapolis, Minn.
6—PROFESSIONAL BUSINESS SERVICE, La Crosse

63—RICHARDS MANUFACTURING CO., St. Paul, Minn.
7B—ROEMER–KARRER COMPANY, Milwaukee
26—J. B. ROERIG & CO., New York City
53—ROSS LABORATORIES, Columbus, O.

50—SANBORN COMPANY, Waltham, Mass.
39—SANDOZ PHARMACEUTICALS, Hanover, N. J.
35—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11—SCHERING CORPORATION, Union, N. J.
23—JULIUS SCHMID, INC., New York City
15—G. D. SEARLE & CO., Chicago, Ill.
4B—SMITH, MILLER & PATCH, INC., New Brunswick, N. J.
5—SMITH, KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
57—E. R. SQUIBB AND SONS, New York City
69—STUART COMPANY, Pasadena, Calif.

20—THERMO-FAX SALES, INC., Milwaukee
81—TRENT PHARMACEUTICALS, INC., New York City

32—ULMER PHARMACEUTICAL, Minneapolis, Minn.
34—THE UPJOHN COMPANY, Kalamazoo, Mich.

7—U. S. VITAMIN CORPORATION, New York City

71—W. T. S. PHARMACEUTICALS, Rochester, N. Y.
72—WALLACE LABORATORIES, Cranbury, N. J.
24—WARNER–CHILCOTT LABORATORIES, Morris Plains, N. J.
36—WARREN–TEED PRODUCTS CO., Columbus, O.
12—WESTWOOD PHARMACEUTICALS, Buffalo, N. Y.
74—WHITE LABORATORIES, Kenilworth, N. J.
42—WINTHROP LABORATORIES, New York City
77—WISCONSIN 7-UP DEVELOPERS ASSOCIATION, Madison

B3—ZIMMER MANUFACTURING COMPANY, Warsaw, Ind.

A SPECIAL ANNUAL MEETING FEATURE

MEDICAL ART SALON

Milwaukee Auditorium, May 11–12–13

Sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin

(See the January and February issues of WMJ for details)

RESERVATION FORMS FOR

Noon Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities and taxes.

MONDAY, MAY 11 (See pages 173 and 174 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. BORGES: IRONIC RETICULOCYTE
2. BOLES: SURGICAL EMERGENCIES IN NEWBORN
3. GARDINER: OBSTETRICIAN AND PREMATURITY
4. STANDER: ANTENATAL PREDICTION OF ERYTHROBLASTOSIS FETALIS

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice. _____

TUESDAY, MAY 12 (See page 175 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. MEYER: RECENT ADVANCES IN THERAPY
1. MOTULSKY: CLINICAL APPLICATIONS OF MEDICAL GENETICS
3. HSIA: JAUNDICE IN NEWBORN INFANT
4. SCHIELE: MAINTENANCE THERAPY WITH PSYCHOTROPIC DRUGS
5. HICKEY: RESUME OF CONTROVERSIAL ASPECTS OF BREAST SURGERY

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice. _____

WEDNESDAY, MAY 13 (See pages 178 and 179 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. EASTWOOD: DEVELOPMENT OF ATELECTASIS DURING ANESTHESIA
2. FREDERICKSON: CLINICAL HYPOTENSION WITH HALOTHANE
3. BIRMINGHAM: USE AND MISUSE OF PATCH TEST IN DIAGNOSIS OF OCCUPATIONAL SKIN DISEASE
4. HALL: FLEXION AND EXTENSION INJURIES TO NECK FOLLOWING REAR-END AUTO COLLISION
5. HARDMAN: NEW CONCEPTS IN DRUG THERAPY OF ANGINA PECTORIS
6. CROW: MEDICAL GENETICS AS PUBLIC HEALTH PROBLEM
7. BUCHTEL: RADIOLOGIC ASPECTS OF ACUTE GASTROINTESTINAL HEMORRHAGE

B. E.E.N.T. LUNCHEON

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice. _____

ANNUAL DINNER, Tues., May 12

DANCING
SHORT SPEECHES—COCKTAILS

$7.00 PER PERSON (Including Gratuities and Taxes)

Number Luncheon Tickets ($2.50 each) . . . . . _____ for $_____

Number Annual Dinner Tickets ($7.00 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____

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the wisconsin medical journal

VOLUME 63/NUMBER 4 APRIL 1964

Symposium on Alcoholism

INTRODUCTION

THE NORTHWEST PSYCHIATRIC CLINIC began its efforts in the field of professional education in the spring of 1963 when the Northwest Psychiatric Clinic Research Center was established. One of the functions of the Research Center is participating in educational activities. The first such activity was a Seminar series in Psychiatry for General Practitioners. The first series was presented under the cosponsorship of the Research Center and the local chapter of the Academy of General Practice. The series became more popular with each session and as a result of this encouragement, the Research Center decided to sponsor a Symposium on Alcoholism. The Symposium was held in April 1963, at the Eau Claire Country Club. Seven outstanding authorities were brought to Eau Claire from various parts of the United States to present their papers. The following papers are those selected by the Editorial Board of the WISCONSIN MEDICAL JOURNAL.

Although the Symposium conflicted with a major medical meeting which was on the same date, there were over 200 physicians from Wisconsin and Minnesota in attendance. The Symposium presented the current concepts of alcoholism and its management. The many requests for copies of the papers presented attested to the success of the meeting. Some of the participants appeared on the local television station, demonstrating to the public that the physicians of the area are concerned about the alcoholic problem and desire to seek its cause and cure.

The program consisted of papers on the philosophy and treatment, management of withdrawal, medical complications, long-range treatment of chronic cases, and a case presentation. Discussion periods were held as well as a social time for the people in attendance.

A separate program was developed for the wives of the physicians who attended. This program consisted of a paper on "The Wife of the Alcoholic." Many of the physicians brought their wives with them, and they reported that they enjoyed sharing in the experience with their husbands.

As a result of this Symposium, the State Medical Society of Wisconsin has joined the Northwest Psychiatric Clinic and the Wisconsin Psychiatric Institute in sponsoring the Symposium for 1964. On April 8, 1964, the Symposium was held on the subject of Depression. Again, leading authorities presented papers. The subject attracted widespread interest since one of the major psychiatric problems in this area is depression.

It is our hope that these outstanding papers on alcoholism will be of interest to you and that you will also have the opportunity to read the papers on depression, should they be approved for publication.—NORTHWEST PSYCHIATRIC CLINIC.

Principles of Comprehensive Therapy in Management of the Alcoholic

By JOSEPH B. KENDIS, M.D., St. Louis, Missouri

■ THE LATE Reverend Fred B. Ford wrote regarding alcoholism, that no problem is solved by definition, yet definitions often help.[1] Probably one of the best is that of the World Health Organization's Subcommittee on Alcoholism: "Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that they show noticeable mental disturbance, or an interference with their bodily or mental health, their interpersonal relations, and their smooth social and economic functioning, or who show prodromal signs of such development."[2] There is also a definition, read so many years ago its source has been forgotten, that stated simply: "An alcoholic is a person who can totally abstain or drink to excess. For him there is no middle of the road."

All too many physicians either make known their displeasure in treating alcoholics or refuse altogether to treat them. Considering that there are in our country some five million of these sick individuals, and also that for each alcoholic there are some five others involved—family, friends, employers, employees—this brings us to the startling figure of 30 million people needing help and either being refused it or offered less than the best.

How often do we hear: "I just can't get anywhere with alcoholics" or "I don't treat alcoholics, it's just a waste of time"? Why is this attitude present; what can we do about it?

At our Alcoholism Treatment and Research Center, our patients are taught to take a look at themselves. Perhaps if we physicians also took a look at ourselves we could find the answers to the questions. Does the fellow who admittedly "can't get anywhere with alcoholics" have the same feeling about diabetics, tuberculars, pneumonia patients, or cardiacs? Of course not—and why not?—because he has a good knowledge of the nature and treatment of these diseases. In making excuses for not treating alcoholics, is not the physician doing the same thing that he will try to convince an alcoholic patient *not* to do? Is he not running away, trying to escape? Undoubtedly, and in so doing he is missing a golden opportunity to accomplish something positive. Anyone who has treated an alcoholic and seen him attain and maintain sobriety cannot help but have a great sense of satisfaction; satisfaction gained by the part he has played in the metamorphosis of an individual whose life was unmanageable into one who has regained a useful place in his family, community, and society.

Thus step number one is to take a good look at ourselves. Should not we as physicians be ready to do something positive about a disease that is one of the greatest public health problems?[3] Of course, the answer can only be yes. This then brings us to step number two. Here we must make an honest evaluation of ourselves, recognize our own shortcomings and overcome them and try to learn all we can about this illness. This leads to step number three, putting this knowledge into action.

When starting to treat an alcoholic, what is the goal to be expected? Usually the answer is "to have a sober patient." But is this our true goal? Let us attempt to teach the

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Presented at a Symposium on Alcoholism, Northwest Psychiatric Clinic, Eau Claire, Wis., April 3, 1963.

Doctor Kendis is Senior Consultant to the Alcoholism Treatment and Research Center and a Consultant on Alcoholism to the Division of Mental Health of the State of Missouri.

patient to become not just a "dry" person, but one who will think like an emotional adult, thus aiding him on his way to a new and better way of living. Dr. Karl E. Voldang has said that ". . . management of an alcoholic is a process of rehabilitation involving the restoration of a dangerously ill citizen again to healthy citizenship; transforming uselessness to usefulness."[4]

A few of the more important things to be discussed with the patient are honesty, tolerance, resentments and how to get rid of them, sensitivity and what to do about it, reality, goals to set for oneself.[5] At first glance, all this seems simple, but take a second look at this list. Just what do we say to the patient, remembering that these are only a few of the problems in his life? In an introduction to Ralph A. Habas' book, *How to Live Without Liquor*,[6] Dr. W. W. Bauer states "Modern recognition that the alcoholic is a person in trouble rather than a mere trouble maker has arisen out of research dealing with alcohol as a drug." True, but we must go one step further. One of my professors in medical school emphasized that we should always treat the patient, never the disease. Nowhere is this more true than in treating the alcoholic.

What do alcoholics need; what is lacking in their lives? And what can we offer them? Probably their most important need is support. If offered support, they will be far more likely to respond positively to treatment. I have often said that I offer an alcoholic patient not sympathy and not understanding, but sympathetic understanding. I also know that alcoholics are supposed to be great at manipulation to attain their ends. Perhaps so, and I do not object being manipulated up to a certain point. But the patients soon learn the limit: they know they are manipulating me and they know that I know it also. Here is the place for discipline, but discipline tempered with kindness: I would much rather be known to my patients as Dr. Joe than as the clinical director. We expect honesty from our patients, but first we must be completely honest with them; and as we expect them to learn tolerance, we must be tolerant of them.

Alcoholics must learn to look at themselves with reality, to set for themselves realistic goals. They must learn how to overcome resentments by the use of charity and forgiveness, and they must learn to have a busy and productive life with no gaps in their day for drinking. Of course there are other and numerous needs of alcoholics; these will come out and the proper responses will be found.

Treatment. The actual treatment of alcoholics can be broken into three parts:

1. Treatment of the acute phase of the disease.
2. Treatment of the chronic disease in:
   (a) the patient
   (b) the family and those closest to the patient.
3. Treatment of the community.

In my opinion, and for a number of reasons, treatment of the acute phase is best started in the hospital. First of all, medication can be controlled and there need be no worry that the patient will overdose (at home the patient might, in an agitated state for instance, take a handful of pills). Pa-

"Always treat the patient, never the disease. Nowhere is this more true than in treating the alcoholic . . . I offer an alcoholic not sympathy and not understanding, but sympathetic understanding . . . Anyone who has treated an alcoholic and seen him attain and maintain sobriety cannot help but have a sense of satisfaction; satisfaction gained by the part he has played in the metamorphosis of an individual whose life was unmanageable into one who has regained a useful place in his family, community, and society."

tients can be watched so that complications such as delirium tremens, hallucinosis, or convulsions do not occur, or if they should occur, treatment can be carried on in a more regulated manner under supervision of trained hospital personnel. Patients need not be on a locked ward, nor, if the staff is properly indoctrinated in treatment, should restraints ever be used. I have seen a patient highly agitated and in a straight jacket brought in by the police. With a few kind words and actions from nursing personnel, the patient quieted down and was perfectly cooperative even though intoxicated. He had been both resentful and fearful of being in the straight jacket; and when he saw that he was to be treated kindly, he responded in a like manner.

During the acute phase of the disease, mephenesin carbamide (Tolseram) in 1.0 Gm. doses will frequently help to control the "shakes." For the patient's nervousness in general, tranquilizers have been found to be most effective and to have the least danger of addiction. A warning here, however, is appropriate. As with any other medication in an acutely ill patient, it is well to know the actions, reactions, and side actions of the particular drug being given, as well as the indications and contraindications. If, for instance, one is aware that some tranquilizers cause hypotension, especially if given while the patient is highly intoxicated, they can be temporarily withheld or given in small doses.

At the start of treatment, if the patient is highly intoxicated, agitated, and needs medication to quiet him, one may hesitate to use a tranquilizing drug due to the possible synergism with alcohol. But there are other agents that can be safely used, such as phenylhydramine (Benadryl) or promethazine (Phenergan), which can be given in 25 to 50 mg. dosage and will temporarily calm the patient until more of the alcohol has been oxidized. Then one of the tranquilizers can be given.

One of the safest and smoothest acting of the tranquilizers is chlordiazepoxide hydrochloride (Librium), which can be started by giving 50 to 100 mg. intramuscularly, followed up by 25 mg. orally three times daily, later cut to 10 mg., and finally to 5 mg. Although side actions to this drug are infrequent, it is well to know and recognize them. They are seen most frequently in elderly, emaciated, or small patients. In order of frequency, the side actions are drowsiness, ataxia, and mental confusion. One also may occasionally see dependent edema. However, if the dose of the drug is decreased or it is stopped for a time, these reactions will reverse themselves. We have noticed little or no drop in blood pressure with chlordiazepoxide. As a precaution, tranquilizing drugs are not used while the patient is highly intoxicated, and larger doses are never given outside the hospital.

"To all physicians: let the alcoholic be a challenge to you. Learn as much as possible about treating his disease. Reevaluate your own attitudes about him and where necessary make changes. Do not be hesitant about working in this field. Helping these people to find themselves will make better and happier families and communities."

Before treatment is started, one must try to obtain as complete a history as possible from the patient and others who might have information about him. How long has he been drinking? What was he drinking, and how heavily? Knowing the rate at which alcohol is oxidized by the body, this information may assist both in estimating the elapse of time before the patient will sober up in deciding on his immediate treatment. At this time also he should receive a complete physical examination with special attention to such complications as head injuries, fractures, heart failure, diabetes, pneumonia, and tuberculosis.

On admission, we believe that the best course is to immediately STOP ALL ALCOHOL. The patient should be on bed rest for 24 hours, or until apparently sober, to avoid falls and subsequent injury and to further facilitate close observation for injuries, complications, or suicide. As the alcohol is gradually oxidized, he will start to show withdrawal symptoms, including tenseness and tremulousness or tremor. Far too many people, even physicians, designate this as delirium tremens, however the patient merely has the "shakes" or tremor. If it were delirium tremens, he would also demonstrate hallucinations or delirium and would be disoriented.

For sleep, one of the nonbarbiturate hypnotics is given and it has been found that after a few days it can be decreased and then discontinued. One hypnotic is worthy of mention because our patients NEVER receive it. This drug, which has been called the dark ages approach to alcoholism, is paraldehyde. Our patients NEVER receive paraldehyde as it is far more addictive than alcohol, it is also toxic, and it has an extremely high synergism with alcohol and the barbiturates.

Anticonvulsants are of value if the course is stormy or if there is a history of seizures. Also, due to the irritative action of alcohol on the gastric mucosa, many alcoholics have gastritis and show such symptoms as heartburn, nausea, and emesis. For this one of the antacids can be given as needed.

Any drugs containing alcohol (paregoric, cascara, elixirs, or most cough mixtures) are never given to our patients because of their alcoholic content.

Nutrition. The patient usually has stopped eating when he or she has started drinking, and various degrees of malnutrition and avitaminosis will be found according to the length of time drinking has continued and how heavily. While a general diet will usually suffice, we do push carbohydrates to replenish the supply of glycogen in the liver. This can be done easily by offering orange juice at frequent intervals. This is high in sugar, vitamin C, sodium chloride, and potassium, and Dextri-maltose, Dexin, and sugar or honey may be added to it to increase the carbohydrate content. Of course the patient's urine is checked at the outset, as this regimen would not be pushed in a diabetic.

An attempt is made to saturate the patient with vitamins by giving intramuscularly, for the first three days, vitamin-B complex with 100 mg. of thiamine hydrochloride added, and also multivitamin capsules daily. The best of the latter are those containing minerals and the various liver fortifiers, such as inositol, choline, and methionine, since the liver undoubtedly has suffered from the malnutrition and it is in the liver that most of the alcohol is broken down.

The Recovery Process. As the patient starts to recover, it may be best if he is kept for a time on chlordiazepoxide therapy. However, it is not too unusual to find that some patients are depressed, and these are switched to mood-elevating drugs such as imipramine (Tofranil) or amitriptyline (Elavil); in some cases these drugs are given and titrated against chlordiazepoxide.

There is usually a great deal of remorse present at about this time and it is now that we can begin to make progress toward the overall arrest of the disease (we always speak of arrest rather than cure) by counseling the patient, trying to show him the positive approach to the maintenance of his sobriety. Most frequently he has previously been warned that if he did not stop drinking he would injure his liver and his brain cells, or he would lose his wife, family, or his job. These negative approaches do no good because the patient knows all the consequences but drinks in spite of them. Our approach is instead a positive one. We try to help him build a solid foundation upon which his new life will stand.

At first the patient is told that while for him drinking was once fun, this is no longer so. If now he stops drinking and maintains his sobriety, he can replace what was fun with happiness, and happiness is peace of mind and is not to be found in a bottle. An attempt is made to show him the fine things attainable through sobriety instead of the dismal ones that will occur if he drinks again. Thus at the very start he is given encouragement and incentive to build his life anew.

During ensuing sessions he is told about honesty, resentments and how to overcome them, facing reality, tolerance (if he expects tolerance he must first be tolerant), and other related subjects. These are not didactic lectures but two-way discussions with an interchange of ideas between therapist and patient. Where there are enough patients under treatment at once, group sessions can be held, and frequently even more will be accomplished in these than in individual therapy. After every session, however, an attempt is made to have a brief individual discussion with each patient. To be most successful, groups should be kept small.

There are Alcoholics Anonymous (A.A.) organizations in almost every community, and they offer a splendid service in aiding patients to stay sober. One should always make use of their services and encourage patients to attend A.A. meetings and take part in their activities. I have had a very close relationship with Alcoholics Anonymous for many years, and I cannot recommend too highly that alcoholic patients be

urged most strongly to participate. A word of warning however: do not expect A.A. to do your job for you; let it be a joint venture.

If a physician has carried through this far, he will find that he is beginning to enjoy working with alcoholics, since in general, "dry" or nondrinking alcoholics are about the most pleasant people one can meet.

The Family. The next phase is that of treating the family. By the time the alcoholic has reached the chronic stage of the disease, a pattern of disorganization has also been set in the family. Truly, alcoholism is a family disease, and it is necessary, if you wish to be successful in treatment, to look beyond the alcoholic himself. Due to the pathologic drinking of one member of the family, the other members are also affected. The spouse starts feeling sorry for herself for having to put up with an alcoholic mate, or she may have had to take over his duties as well as her own, thus becoming the dominant (and domineering) member of the family. The children are neglected, and being subjected to one dominant and one ineffective parent, their attitudes are warped. Before we have finished looking, we find not just a "sick" individual but a "sick" family.

It is most important to work with all members of the family, getting them to think straight and function together, each seeing what positive factors he can put into, not what he can get out of family life. It is important that all live for today, and out of today build a tomorrow. And for all, yesterday is a closed book, a slate wiped clean. The alcoholic cannot reach back and change what he or she did yesterday nor can any of the other members of the family. So there must be a concerted effort not to bring up the past, nor to reproach or remind each other of former mistakes, but as a team to work out today's problems and plan for the future.

The Community. It is an established fact that alcoholism is a disease affecting a large segment of all communities. Its treatment thus becomes a community responsibility. But how does one awaken a community to this responsibility? There is still a stigma attached to being an alcoholic, though less than in former times, and the best way to overcome this is through an informed community. Here is the area in which education of everyone is concerned, and all methods of communication should be used, including the lecture platform, radio, television, newspapers, and the schools.

In conclusion may I say to all physicians: let the alcoholic be a challenge to you. Learn as much as possible about treating his disease. Reevaluate your own attitudes about him and where necessary make changes. Do not be hesistant about working in this field. Helping these people to find themselves will make better and happier families and communities.

"Treatment of the acute phase is best started in the hospital. For the patient's nervousness in general, tranquilizers have been found to be most effective and to have the least danger of addiction . . . a warning, however: it is well to know the actions, reactions, and side reactions of the particular drug being given, as well as the indications and contraindications."

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Complications of Alcoholism and Their Treatment

By MARTIN D. KISSEN, M.D., Philadelphia, Pennsylvania

■ IN DISCUSSING the complications of chronic alcoholism, it is necessary to understand that we are examining physiologic and psychologic changes produced by the continued excessive use of alcohol over a long period of time. The systems most often affected are the gastrointestinal system, the nervous system, and the brain.

As for the incidence of complications, there were 821 admissions at the Saul Clinic from March, 1961, until March, 1962. Of this number, there were 21 patients (2.5%) with convulsions, 38 patients (4.6%) with alcoholic hallucinosis, 9 patients (1%) with delirium tremens; and 40 patients (5.0%) with all gastrointestinal complaints including hepatitis, gastritis, and pancreatitis.

Acute Gastritis and Enteritis. This complication is usually due to chemical irritation of the mucous membrane of the gastrointestinal tract. Mental distress, anxiety, and a sense of frustration are usually associated with this inflammatory condition. Immediate withdrawal of the alcohol will relieve the symptoms, as will gastric sedatives and a bland diet. Drugs customarily employed in gastrointestinal cases to reduce motility and soothe the inflamed membranes are also of value. The use of some of the tranquilizers (chlordiazepoxide, chlorpromazine, and promazine) will often allay the accompanying nausea and vomiting. In many cases, however, it is necessary to utilize suggestion and emotional support to relieve the symptoms.

Presented at a Symposium on Alcoholism, Northwest Psychiatric Clinic, Eau Claire, Wis., April 3, 1963.

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Varices of the Esophagus and Cardiac End of the Stomach. This condition probably occurs much more commonly than is suspected. Its danger lies in the possibility of hemorrhage: such signs as vomiting blood, tarry stools, signs of shock, pallor, low red blood cell count, low blood pressure, and other obvious evidence of acute hemorrhage must be borne in mind; and at their first indication, immediate treatment should be instituted. The general regimen for acute hemorrhage may be used, including complete sedation and quiet. Intravenous infusions of saline solution as well as blood transfusions may be necessary. Where the hemorrhage continues, use of Sengstaken or the Patton tube may be indicated. The tube is passed into the stomach, the bulb inflated to 20 to 30 mm. Hg., and left in place for 20 to 48 hours before deflation. After deflation, the patient should be observed for at least 12 hours to make sure there is no recurrence of the hemorrhage. If no bleeding occurs, the tube may then be removed.

Cirrhosis of the Liver. While it has been established that alcoholism is not the only cause of cirrhosis, the basic cause being the lack of necessary nutritional elements in the diet, cirrhosis is one of the very common complications of chronic alcoholism. However, the liver is a very hardy organ and can be subjected to a great deal of abuse before the condition becomes irreversible. Administration of the necessary vitamins and minerals and an adequate diet in the early stage of the disease will usually result in recovery of the liver to its normal functioning. In extreme cases and in cirrhosis of long duration, where the destruction may be so severe that complete recovery is not possible, the above measures and, where indicated, injection of liver extract or vitamin B_{12} will help

support the diseased organ. In some cases, surgery has been utilized in order to establish a collateral circulation in the liver in an effort to augment the portal system.

Acute Lethal Alcoholism. Acute lethal alcoholism occurs when ingestion of alcohol raises the blood concentration sufficiently to cause death. The alcohol acts the same as an overdose of anesthetic, producing death by a complete anesthesia of the vital centers of the brain. The percentage of alcohol in the blood is a function of the number of drinks, body weight, and time elapsing since the first drink. For example, if a person weighing 150 lb. drinks 2 volume ounces of 100 proof whiskey (or 2 bottles of beer) within an hour, he would have a blood alcohol level of 0.05%. If the same person were to drink 5 volume ounces over a 5-hour period he would also have a blood alcohol level of 0.05%. The individual's general physical health will naturally have a bearing on the potentially "lethal" (toxic) effects of alcohol.

Alcoholic Neuritis. In the early studies on alcoholism, this complication was found to be so prevalent that many investigators would not make a diagnosis of chronic alcoholism unless it were present. The symptoms are related to the peripheral nerves, resulting in pain, paresthesia, and motor paralysis, sudden in onset and quite disturbing to the patient. It is believed that a vitamin B_1 deficiency causes a degeneration of the myelin sheath of the peripheral nerve involved and then the alcohol produces its toxic effect on the nerve tissue. The treatment is to give the patient large doses (300 to 400 mg.) of thiamine chloride hydrochloride and, of course, to stop the alcohol intake.

Alcoholic Epilepsy. Some alcoholics who never show epileptic tendencies when abstinent will suffer from alcohol-induced seizures a day or more after the end of a drinking bout, occasionally while actually drinking. These convulsions usually result from a prolonged drinking spree, during which proper nutrition has not been maintained, and have a decided tendency to become more frequent and more severe as the individual continues to drink. On some occasions a convulsion may usher in delirium tremens.

The acute attack of alcohol epilepsy can usually be controlled by prompt injection of 0.12 Gm. of phenobarbital sodium. However, these patients should not be given any controlling sedation during their periods of "drying-out" because the convulsions occur only as a result of their drinking; and, as is well known, the concurrent use of alcohol and barbiturates is extremely dangerous and contraindicated.

Psychomotor Agitation. Psychomotor agitation, with symptoms of restlessness, nervousness, insomnia, anorexia, and depression, is one of the most distressing symptoms observed in alcoholic patients during the period of recovery from bouts of acute intoxication. For many years, an attempt was made to relieve these symptoms by means of paraldehyde, chloral hydrate, bromides, and barbiturates. We have learned that these were not good because they produced greater dependence and even addiction in the patient. In this connection, an account of our more recent experience with chlordiazepoxide (Librium) is in order.

"We have learned that the use of paraldehyde, chloral hydrate, bromides, and barbiturates to relieve psychomotor agitation, with symptoms of restlessness, nervousness, insomnia, anorexia, and depression, during the alcoholic's period of recovery from bouts of acute intoxication is not good treatment because these drugs produced greater dependence and even addiction in the patient."

Eighty consecutive admissions to Saul Clinic were selected for this study. On admission, each patient received intravenously 1,000 ml. of 10% glucose in water and 1,000 ml. of 5% glucose in saline, both solutions containing vitamin-B complex. An additional 1,000 ml. of 10% glucose was given 12 hours later. Throughout the period of hospitalization, each patient was also given daily intramuscular injections of 100 mg. of hydrochloride as well as daily oral doses of other vitamin-B fractions and ascorbic acid.

In addition, the odd-numbered patients, if admitted during the day, were given at bedtime, 100 mg. of chlordiazepoxide either intravenously, intramuscularly, or orally; if admitted after 9:00 p.m., they received the same dose of chlordiazepoxide immediately. This was followed up with 10 mg. by mouth four times daily for the remainder of the hospital stay. The even-numbered patients used as controls, were given either placebo, sodium amytal and secobarbital sodium (Seconal), chlorpromazine (Thorazine), promazine (Sparine), or other tranquilizers.

The subjective symptoms of psychomotor agitation were translated into objective findings in the areas of sleep, appearance, appetite, tremor, depression, and nervousness. Figure 1 is a check sheet showing how this was recorded; the numbers at the top of the page refer to eight-hour intervals. The scores of controls compared with those of the patients receiving chlordiazepoxide are shown in Figures 2 and 3. All patients with other complications were ruled out.

Figure 2 illustrates the total response at the eight-hour examinations in the six areas described, the worst possible response being 15 and the optimum response 6. The curves compare the rate of drop of the controls with that of the patients receiving chlordiazepoxide. The most significant difference is noted at the eight-hour examination at which time the chlordiazepoxide curve dropped by 4.3, the control by only 0.5.

Figure 3 shows definitely that the chlordiazepoxide-treated patients arrived at the optimum response level much sooner than the controls. After 40 hours, 21 (53.8%) of the chlordiazepoxide-treated patients and only 2 of the controls had reached this level. After 80 hours, the figures were 90 per cent for the chlordiazepoxide-treated patients compared with 72 per cent for the controls.

Alcoholic Hallucinosis. Hallucinosis, as the name indicates, is characterized by auditory or visual hallucinations, or both. Its onset usually occurs in a patient who is on the road to detoxification and who is correctly oriented, whose sensorium is clear, and who preserves striking equanimity in spite of what he is "seeing" and "hearing." By contrast, in delirium tremens the patient is disoriented, in poor contact, and shows severe psychomotor agitation and evidence of great fear or terror. Hallucinosis is treated by higher doses of chlordiazepoxide along with

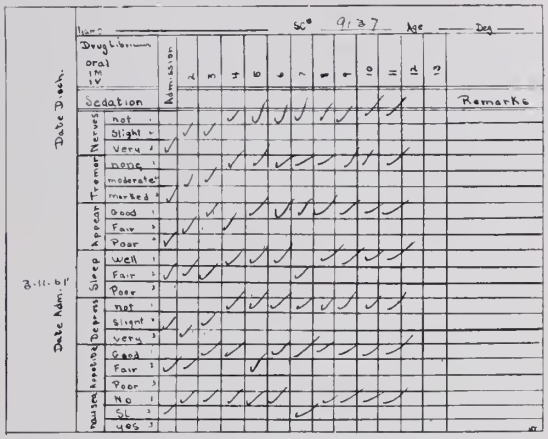

Fig. 1—Check sheet showing patient's symptoms of psychomotor agitation; numbers at top refer to 8-hour intervals.

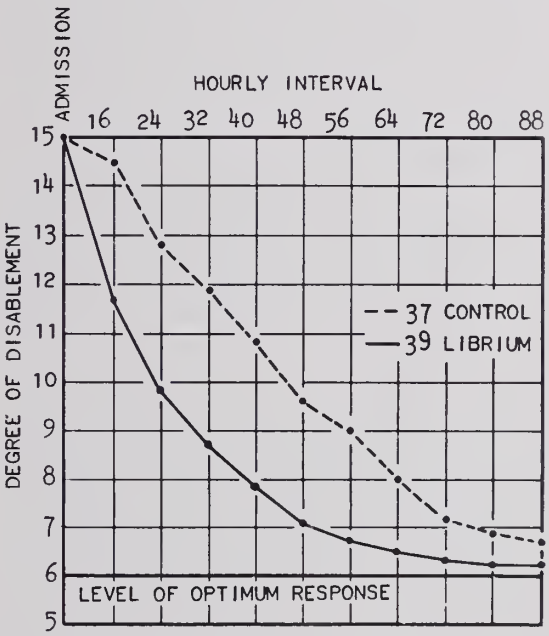

Fig. 2—Composite curves showing total response in all areas measured comparing chlordiazepoxide with controls.

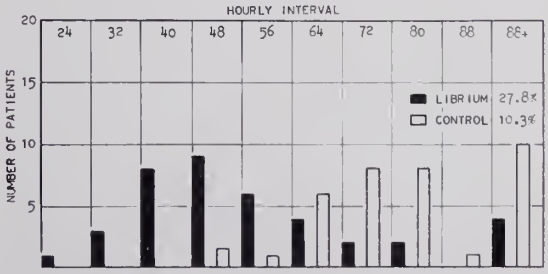

Fig. 3—Composite graph showing time necessary to reach baseline optimum response; comparison of chlordiazepoxide with controls.

nicotinic acid, 800 to 1,000 mg. per day. While ordinarily self-limited and disappearing in 1 to 6 days after onset, in a very small percentage of cases the hallucinations will continue and become associated with an organic brain syndrome. Not infrequently hallucinosis attributed to alcoholism constitutes the onset of a paranoid psychosis, usually schizophrenic in character.

Delirium Tremens. Delirium tremens is fairly common and may occur after prolonged drinking, upon withdrawal of alcohol after prolonged drinking, or as a complication of an intercurrent infection. It is often misdiagnosed since many residents and physicians forget that both hallucinations and tremors must be present. The characteristic picture is one of intense excitement, delirium, and coarse tremors, sometimes accompanied by convulsions of the grand mal type. Marked confusion with disorientation differentiates this condition from hallucinosis; but although confused as to time and place, the patient almost never loses his identity. As a rule, both auditory and visual hallucinations are present. These are markedly vivid and often assume the forms of animals or bizarre combinations of animal bodies with human heads and vice versa, all over the room and on the patient's body.

"Delirium tremens is fairly common . . . It is often misdiagnosed since many residents and physicians forget that both hallucinations and tremors must be present . . . This is still a very serious complication and can produce death . . ."

This is still a very serious complication and can produce death due to bronchopneumonia, heart failure from exhaustion, or the so-called thalamic hyperthermic syndrome with temperature as high as 107 or 108 F. at the time of death. It must be treated by every available means: adequate hydration (3,000 ml. of fluid daily) including protein as well as glucose and vitamins, careful check on the cardiovascular and respiratory systems, and heavy sedation with tranquilizing drugs, or if necessary barbiturates, to combat the exhaustion. ACTH in doses of 25 mg. every 4 to 6 hours is also helpful.

Pathologic Intoxication. This condition may cause some difficulty in proper diagnosis. When, without apparent preexisting mental disorder, there is a marked behavioral or psychotic reaction with an acute brain syndrome after minimal alcohol intake, the psychiatric diagnosis is *acute brain syndrome*, "alcohol intoxicating." When a preexisting psychotic, psychoneurotic, or personality disorder is made more manifest after minimal alcohol intake, the case is classified under the diagnosis of the underlying condition.

Despite the nosologic problem, the condition is generally characterized by a precipitous and almost maniacal response to a comparatively small amount of alcohol. The patient may become inordinately aggressive and several strong individuals may be required to prevent him from injuring himself or others. He may take off his clothes inappropriately or give away all of his money. The list of unrealistic and bizarre behavior is extensive. It is postulated that in all such cases the alcohol acts as a trigger mechanism releasing underlying psychological tendencies from inhibition.

Reasoning with the patient may be somewhat effective, but direct, decisive action is usually necessary. Treatment consists of heavy sedation or temporary custodial care until the acute phase passes.

Korsakov's Syndrome. Korsakov's psychosis falls under the general diagnostic category of chronic brain syndrome, "alcohol intoxication." The differentiation from acute brain syndrome is made when it becomes apparent that permanent, irreversible damage to the brain has occurred. Korsakov's syndrome is characterized by amnesia, confabulation, peripheral polyneuritis, and confusion as to time and place but not as to person. Superficial examination does not always reveal the extent of memory loss since the patient has become adept at confabulation, and anxiety over amnesia is frequently not clinically manifest.

Prognosis is not always immediately determinable. Some severe cases show gradual improvement over a period of weeks or months, presumably as new associative pathways in the brain are substituted for those which have been damaged; others remain unchanged and institutionalization is often necessary.

Since it is now believed that the syndrome occurs as a result of inadequate diet, the essential nutritional elements, including vitamins (especially B complex) and minerals, must be supplied in sufficient amounts.

Wernicke's Disease (Hemorrhagic Polioencephalitis, Superior). This is characterized by limited movements of the eyes due to partial paralysis of the eye muscles. Mental changes include intense excitement, convulsions, and clouding of consciousness, which may lead to stupor and coma. There are usually pathologic reflexes with muscular rigidity. Tendon reflexes are absent. Since this complication is also considered to be the result of deficient nutrition, an adequate diet, with large doses of thiamine and other vitamins and minerals is indicated. Not uncommonly complete restoration fails to occur. Confabulation resembling that in Korsakov's syndrome is often a residual effect.

Marchiafava's Disease (Primary Degeneration of the Corpus Callosum). This was once thought to be due to alcoholism. With only 100 cases reported in the literature, it has been determined that this complication resulted not from alcohol but from the metallic impurities found in wine as the result of processing.

Summary. A comprehensive discussion of the complications of chronic alcoholism has been presented. Where feasible, the causes and treatments of these various manifestations, both physiologic and psychologic, have been outlined. A controlled study of the use of chlordiazepoxide in the treatment of psychomotor agitation has been reported.

Franklin, Thompson and Eighth Streets (2).

THE CYTOLOGIC DIAGNOSIS OF CANCER

A summary of the workload in the cytology section for the past fiscal year is given in Table 1, compiled for the annual report. During the year there was an overall increase in numbers of specimens submitted, with greatest increments noted in vaginal and sputum cytology. In this table, the percentages of abnormal specimens from various sites is noted. For material originating in the urinary system, gastrointestinal tract, lungs, and miscellaneous sources such as breast, the overall percentage of abnormal specimens is 9.1 per cent. These specimens are from patients in whom the diagnosis of cancer is strongly suspected.

Vaginal smears, on the other hand, show an overall percentage of 1.35 per cent abnormal cells, or one-seventh the number from other sites. This lower detection rate reflects the fact that most vaginal smears are performed as a screening test on healthy women to detect early cancer. The usefulness of the cervical-vaginal smear in finding unsuspected cancer is shown by the fact that during this period 314 cases of in situ squamous cell carcinomas of the cervix were detected. In addition, 165 patients were found to have invasive cervical carcinoma. The overall detection rate of cervical cancer was 0.53 per cent. Thus, 1 in 200 women who were examined by the Pap smear method was found to have cervical carcinoma, many cases of which were in the early, curable stages.

TABLE 1—*Cytology Laboratory, 1962–1963*

Cytology Class	Vaginals	%	Body Fluids	%	Urine	%	Gastric	%	Sputum	%	Misc.	%	Total	%
Negative	88,313	98.6	305	79.0	224	88.9	198	90.0	3,918	90.8	807	92.3	93,765	98.1
Atypical	677	0.75	3	0.7	2	0.8	2	0.9	101	2.3	20	2.3	785	0.8
Suspicious	200	0.22	6	1.5	11	4.3	0	0	48	1.1	8	0.9	273	0.3
Positive	341	0.38	77	19.7	16	6.3	20	9.1	247	5.7	39	4.5	758	0.8
Total Abnormal (A-S-P)	1,218	1.35	86	22.0	29	11.5	22	10.0	396	9.1	67	7.6	1,816	1.9
Grand Totals	89,529	100	391	100	253	100	220	100	4,314	100	874	100	95,581	100

—NEWSLETTER, Wisconsin State Laboratory of Hygiene, December 1963.

Management of Acute Alcohol Withdrawal Symptoms

By JOSEPH F. CHAMBERS, M.D., Washington, D. C.

■ THIS REPORT, an approach to the medical withdrawal of the acutely ill alcoholic, is based on experience with some 3,000 alcoholics over the past two years at the District of Columbia General Hospital, a 1,250-bed facility serving a population of almost one million people. The average number of alcoholics admitted is 1,500 per year, constituting over one-third of all admissions to the Department of Psychiatry.

The Alcoholic Unit, a 35-bed ward in the Department of Psychiatry, is sufficiently identified as a separate area to avoid the alcoholic's reluctance to associate his problem with anything "mental." Acceptance of the problem initially as having anything to do with a neurosis is impossible for most alcoholics because such a concept adds to their already unbearable feelings of inadequacy and inferiority. But in a group with the same illness the patient can identify and socialize with other alcoholics, relieving the feeling he has of being different, cast out, and alone.

The primary function of the Alcoholic Unit is the medical management of withdrawal symptoms of large numbers of alcohol addicts coming from several sources but chiefly from the Emergency Room at D. C. General Hospital. Patients are seen by the resident physician in Psychiatry and are admitted specifically because of the severity of their withdrawal symptoms. Grave medical and surgical problems are not admitted to Psychiatry, being treated in the medical and surgical divisions. However, medical problems are routinely admitted when the chief complaint is alcohol withdrawal. These Emergency Room admissions are sick patients, over half of them in or impending delirium tremens. Others have had convulsions prior to admission or have histories of seizures. Most of them have had previous, some repeated, admissions.

While chronic alcohol intoxication also results in change in the social, behavioral, and familial areas, for the physician the presenting changes are metabolic and clinical. Calorie wise, alcohol is a fuel, nothing more; it is void of vitamins, proteins, and minerals. When, as in the alcoholic, ethanol becomes a major source of fuel, protein, vitamin, and mineral deficiences begin to appear. Since alcohol is also a diuretic, the alcoholic becomes dehydrated. Clinically, he is restless, tense, agitated, often depressed, guilty, and anxious. He demands symptomatic relief and obtains it with more alcohol. Abrupt cessation of drinking in the alcoholic results in the development of a series of progressive symptoms whose severity is roughly proportional to the length and amount of drinking preceding withdrawal. Pharmacologically, ethyl alcohol is a central nervous system (CNS) depressant. The prolonged excessive use of this drug results in adaptive cellular metabolic changes seen clinically as withdrawal symptoms.

The patient shows signs of CNS involvement by agitation, confusion, and tremulousness. He may be dizzy and ataxic. Further addiction is seen in the development of delirium, hallucinations, and even convulsions. The ever-present possibility of head injury in the acute alcoholic must be remembered; head injury may be masked by the withdrawal.

The cardiovascular system shows tachycardia, premature ventricular contractions, and other arrhythmias. There is substantial systolic and moderate diastolic hypertension. The patient has hemoconcentration from his

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Presented at a Symposium on Alcoholism, Northwest Psychiatric Clinic, Eau Claire, Wis., April 3, 1963.

Doctor Chambers is Medical Officer, Alcohol Admission Service, District of Columbia General Hospital.

dehydration. Leukocytosis and variable fever are usually present.

Gastrointestinal symptoms are prominent, varying from anorexia and mild malaise to nausea, vomiting, and diarrhea. The patient may have modest hepatic congestion or be moribund with florid cirrhosis, ascites, and jaundice.

The shaking alcoholic who is in or impending on delirium tremens is anxious, frightened, terrified, often beyond our comprehension. These patients can be suicidal. They often convulse and behave in a bizarre psychotic fashion. At this point, and well before it, they are valid medical and psychiatric emergencies.

The medical treatment of acute alcohol withdrawal is directed primarily to the correction of the disturbed physiology. This involves sedation, correction of fluid balance, and vitamin, mineral, and protein replacement.

Drug Therapy. The use of tranquilizing drugs has brought about a vast change in treatment. Chlordiazepoxide hydrochloride (Librium), currently the drug of choice, produces greater muscular relaxation than other agents, less drowsiness, and less hypotension.[1] A recently recognized and important property of the drug is its anticonvulsant effect. This is of particular importance in the treatment of alcoholics where withdrawal convulsions are a grave and occasionally fatal complication. The effect of chlordiazepoxide on the blood pressure seems to be cumulative after large doses. There is no sudden initial reaction; this is an advantage over the phenothiazines. (Our experience at D. C. General Hospital with chlordiazepoxide,[2] chlorpromazine, and trifluoperazine[3-5] have been published elsewhere).

The agitated alcoholic is treated as soon as he is seen. Many factors influence initial drug dosage: agitation, tremulosity, delirium, convulsions, age, muscle mass, the presence of intoxication, and the degree of dehydration and fever.

Chlordiazepoxide is given 50 to 200 mg. intramuscularly on admission. This is repeated 1 to 6 times in the first 36 hours depending upon the degree of agitation and delirium. Significant relief of even the severe cases occurs within 36 hours. High dosages are continued until this substantial relief takes place. At this point, medication is sharply decreased and changed to the oral route: 25 to 50 mg. three times a day for 2 to 4 days. The patient is drug-free 1 to 2 days prior to discharge.

Chloral hydrate, 1.0 to 1.5 Gm., is used for bedtime sedation, and with chlordiazepoxide, usually provides restful sleep from which the patient is readily aroused. We no longer use barbiturates for bedtime sedation; as sedatives for alcoholics they are effective, yet frequently produce intoxication instead of hypnosis, and are also lethal drugs with addiction liabilities.[6] We do not use paraldehyde: its odor is offensive, its margin of safety inferior, and its addictive properties widely known.

Grand mal seizures seen in alcohol withdrawal states have been aptly called "alcolepsy." Formerly diphenylhydantoin and phenobarbital were routinely given to all patients with a history or an actual episode of convulsions; but since the advent of chlordiazepoxide, withdrawal seizures are rare at D. C. General Hospital. Diphenylhydantoin is still used, prior to and after discharge where there has been an actual seizure, and phenobarbital in the acute convulsive crisis to insure control.

"The shaking alcoholic who is in or impending on delirium tremens is anxious, frightened, terrified, often beyond our comprehension. These patients can be suicidal."

Fluid, Food, Rest. Correction of the fluid imbalance has not been found to be a problem in the large majority of cases. With tranquilizers, it is quite possible to hydrate orally. Fluids are available and encouraged, and are forced on the sicker patients. Less than 10 per cent have been found to require intravenous fluid therapy. The patient is given an ample nourishing diet, with milk and fruit juices between meals, and rests for two hours after the noon meal and for nine hours at night. The alcoholic in the throes of a drinking bout does not eat nor does he really rest; the sleep he catches is fitful and of short duration, and the importance of rest and food in his recovery has long been recognized.

Vitamin replacement therapy is accomplished by either oral (multivitamin capsules) or parenteral administration. With

"Treatment of acute alcoholic withdrawal ontside the hospital involves several problems not encountered in the controlled hospital setting. Intoxication, family strife, abuse of medication—one or all may confnse the treatment pictnre. However, alcohol withdrawal often can be managed in the home."

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the sicker alcoholic, where there is evidence of weight loss, cirrhosis, and delirium tremens, intramuscular B-complex and C vitamins are given daily until discharge. Antispasmodics are used frequently. Chlordiazepoxide seems to have an autonomic quieting effect by itself in most cases. Others require anticholinergics and gels to obtain relief from the discomfort caused by gastritis and low-grade peptic ulcers.

A major advantage of hospital treatment of the alcoholic lies in the substantial advances in nursing skills. Good clinical judgment by experienced and interested personnel is vital, since signs pointing to impending convulsions or relapse into delirium tremens can be recognized if they are known and looked for knowledgeably.

In some toxic long-term alcoholics, the acute brain syndrome does not clear in 3 to 4 days. They pass from the acute, agitated, delirious stage to an intermediate period of confusion and disorientation marked by severe memory loss. These patients rapidly show signs of sedation with medication. Treatment here involves reduction or discontinuance of medication. Only that necessary to control agitation and insure sleep is used. Fluids, parenteral vitamins, and vigorous nursing care generally resolve this intermediate phase within 10 to 20 days. These patients are peculiarly prone to bronchopneumonia and may have some liver damage, but will do surprisingly well with good nursing care and close medical supervision. Many recover rapidly; for others, complete recovery may take many months; some do not improve at all, remaining confused and disoriented with permanent organic damage. These unimproved patients are committed to St. Elizabeth's, the Federal Mental Hospital for the District of Columbia.

Therapy in the Home. Treatment of acute alcoholic withdrawal outside the hospital involves several problems not encountered in the controlled hospital setting. Intoxication, family strife, abuse of medication—one or all may confuse the treatment picture.

However, alcohol withdrawal often can be managed in the home. In many localities it has to be handled there, since general hospitals refuse to admit on this diagnosis alone. This refusal stems partly from the mistaken idea that alcoholics are unmanageable. The Alcoholic Unit at D. C. General Hospital is the quietest, cleanest unit in Psychiatry. With an average census of 30 patients, not more than 2 are in restraints at any one time, and these 2 are usually quiet. The fairly sober, sick alcoholic who wants to get well is an eminently manageable patient.

Treatment in the home is quite possible provided certain ground rules are followed. Patients, when seen, should be sober or nearly so, and they must be interested in treatment. (It is pointless to make a house-call at the family's request on a still drinking alcoholic who has a case of whiskey and is maudlin-drunk). The patient should be willing to attempt to follow a prescribed course of treatment. If at all possible, an interested family member should be the nurse, supervising the patient, giving him his medication, encouraging and providing fluids and later food.

Often, after the first day or two of treatment, someone from the local Alcoholics Anonymous (A.A.) group may help out

here. However, A.A. is interested only if the patient is interested. It behooves the physician treating alcoholics to have some understanding of A.A. and to have contacts with these fine people.

19th Street and Massachusetts Ave., SE. (3).

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CANCER CONTROL OBSTACLE NUMBER ONE: THE PATIENT

ROBERT J. SAMP, M.D., Madison, Wis., *Ohio State Medical Journal,* November 1960.

Doctor Robert Samp of the Tumor Clinic at Wisconsin University Hospitals published in the Ohio State Medical Journal a paper on patients lost to follow-up. The study was made of Wisconsin patients referred to University Hospitals by several hundred Wisconsin physicians.

A review of 500 consecutive cancer cases followed for three years or more showed that 364 (73%) of these patients needed further treatment. It was, therefore, reasonably assumed that about 73 per cent of those failing to return were also in need of further help or treatment. This prompted the study on 300 cancer clinic patients who either never returned or who made a few visits, then quit returning.

All of the 300 patients in this study had been sent two or more reminder letters asking them to make new appointments. The referring physicians were also contacted with the same request. A survey questionnaire was sent to both the referring physician and to the patient. If there was no response to questions about not returning, a further questionnaire was sent to a relative. Further information was also obtained from county health nurses and local medical officials.

The first discovery was that 10 per cent of the 300 who failed to keep follow-up appointments never went back to their local physician either. Twenty-six of 102 patients who never returned after their initial treatment and diagnosis never reported back to their own physician again.

It would seem from results of the survey that there are many patients lost to the medical profession simply because the patients decide against anything further being done. This shifts the blame to the general public somewhat.

Those cases where the physician and patient had agreed on their own local follow-up were not considered as cancer control obstacles. Additionally, cases where advanced age, extreme distance to travel, the indigent or transient status of the patient, or his terminal state made the impossibility of follow-up understandable were not surveyed further.

The survey pointed out that correspondence with the patient is extremely inadequate. Most of the patients are fairly aware of what they are doing and seek help when they need it rather than being prompted by an outside agency to do so. Very few patients respond to our reminder letters concerning their missed appointments and the importance of follow-up. They ignore the instructions to write for new appointments and rarely give reasons why they missed their previous ones. Many of the same factors that cause patients to miss appointments in the first place are responsible for their continued failure even to maintain correspondence.

Long distance travel was mentioned often as a big reason for not returning. Economics play a big role in missed appointments. There is still a big gap between medical insurance and welfare, between poverty and charity. Another understandable reason for not returning is the language barrier with resultant misunderstanding. There is a fair percentage of state and charity patients who have no permanent address or place to call home. Age in itself makes a big difference. Yet, follow-up is essential to survival and to cancer control. When can it be waivered or altered? What is the fate of these patients who break off contact with the physicians?

Of special significance in this study were those excuses which were not so legitimate and logical. Such comments from patients in the survey as 'what cancer?', 'what follow-up appointment?', 'what is the Tumor Clinic?', were not uncommon. Even after informing the patient at discharge about the return, giving him an appointment card, stressing the importance of the follow-up, and sending the summary letter to the physician with a set of instructions, these patients continued to express disbelief, ignorance, lack of directions, and denial of any arrangement or appointment or even having a 'tumor.'

Special personal information was supplied by friends, relatives and spouses of the patients and

this information was of special help. These sources reported that (1) the patient had said little if anything about his case, (2) denied that he had anything seriously wrong, and (3) said nothing about a return appointment. Further questioning of these patients brought out the presence of frank fear, ignorance, repression of facts, and even prevarication.

These peculiar feelings and behavior are not necessarily unique to the state of Wisconsin. This University Hospital services 71 counties (the entire state outside of Milwaukee County) and draws from a rather heterogeneous, predominately Caucasian population. Midwifery, voodoo, and superstition are not common among our people, who are generally a very solid, religious, hard-working group. There is proof that, at least in this survey sample and among certain cancer patients, fear and apprehension must be understood and appreciated if we are to control cancer.

Some patients complain that a 10 or 15 minute examination wasn't sufficient time to justify a long trip, so they stopped returning. This finding in the survey taught us never to rush the patients and to give them ample opportunity to ask questions and to express themselves.

Disease-free and uncomplicated cases are naturally given less attention and patients understandably complain more about the little time allotted to them.

It was interesting that the 'atmosphere' of the Clinic was considered unhealthy by some patients. By this, one man meant the air he breathed, fearing he would catch something from the other cancer patients. Others explained 'atmosphere' as the sight and presence of sicker patients which reminded them that they too some day would progress to this point, they felt. Special arrangements are now made to have windows open, fans in motion, some simple plants, and now especially to separate the stretcher or terminal cases from the walk-in patients as well as to 'space' those individuals with bad odors and obvious advanced lesions which show.

The survey brought out the suspected fact that the Tumor Clinic competes with nonmedical practitioners and other 'treating' professions. Patients admitted being persuaded to have their troubles corrected by special prayers, by manipulation of displaced nerves, bones, and organs of the body. Mention was made of being informed by neighbors, relatives, and other well-meaners who had read about special gadgets, machines, and secret drugs that would be of help.

In our series of 'no-returnees,' 11 admitted or were reported to have visited out-of-state institutions whose reputation classifies them as unorthodox.

Close cooperation with the patient's own home physician insures that better care is given between follow-up visits. Relatives are kept informed of the patient's progress. Symptomatic and palliative means of therapy are routine when all curative means are exhausted.

Complete cancer examination, special laboratory and clinical equipment, and phenomenal cancer chemotherapeutic agents are worthless in cancer control if the patient or patient-to-be is unavailable or if he fails to follow-up on his case and to seek further help. Fears, ignorance, time, money, and distance separate the potentially curable from the present worthwhile means of treatment. Such cancer control obstacles prove to be far more numerous in this survey than heretofore appreciated.

Initial diagnosis and treatment are a portion of the fight against cancer and complete care means a regular interval follow-up. Otherwise, there is increased suffering and loss of life.

How much attention are we paying to the human frailties, the quirks, and superstitions of patients or to the public generally in matters medical? How much emphasis in our cancer education is given to the importance and necessity of lifetime examinations and treatment after cancer diagnosis and therapy? What misunderstandings arise in a traumatic experience such as with cancer, and what weaknesses are evident when a patient knows he is in this category? What percentage of complications, recurrence, earlier death, can be attributed to these factors?

The results of this survey emphasized a need for new approaches and more attention to public cancer education as well as lay-medical education in general. It is important that physicians understand why patients purposely avoid medical attention and why some people hide symptoms, refuse medical aid, or fail to take advantage of worthwhile treatment. It seems that some patients can be persuaded easily by themselves or by others to forget about the seriousness of their disease and welfare and to seek other means of help or to do nothing at all about the condition.

Finally, this survey should remind us that there remains much to know about human nature.

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Long Range Treatment of the Alcoholic Patient and His Family

By EBBE CURTIS HOFF, Ph.D., M.D., Richmond, Virginia

■ THE CARE OF alcoholics presents so many special problems, requires such complex therapeutic planning, and makes such demands upon the therapists that some hesitate to undertake long-term therapy of these patients. Yet if therapists, patient, and family sustain reasonable and realistic expectations of therapy, and if therapy is based upon sound diagnosis and prognosis, with proper flexibility and resourcefulness, large numbers of these patients do very well and their care can be exceedingly rewarding to all. Alcoholics have been cared for successfully in psychiatric settings, in specialized alcoholism clinics, and by general practitioners, clergy, and workers in various community agencies. For many, the fellowship of Alcoholics Anonymous has provided a remarkably successful regenerative community in which alcoholics have not only found sobriety but also a new way of life for themselves as well as for their families.

One should remember at the outset that alcoholics do not constitute a uniform population group but are very different one from another. Alcoholism appears to be a complex psychobiologic disorder of behavior whose etiologies are not fully understood. The illness is characterized, in general, by a progressive loss of control of alcohol intake, increasing disturbance of function, and a need to use alcohol to maintain integration and to handle psychologic and situational problems. An alcoholic is one who, if he drinks, cannot guarantee his behavior. Alcoholics are a mixed group of sick people of a variety of educational, social, and cultural levels, of many personality and body types, of both sexes, of various ages, and of virtually all nationalities and racial strains. There are cultural, racial, and probably metabolic differences in the prevalence of alcoholism, but these differences are not well understood. No specific and characteristic alcoholic personality has been defined in spite of efforts to do so. Most of these patients in the course of their illness become deeply disturbed psychologically and many are psychiatrically ill before their alcoholism becomes manifest. Nevertheless, it is not possible to assign any single psychiatric diagnosis to the majority of alcoholics; rather, in this respect, also, they differ widely one from another.

The importance of a sound, careful diagnosis in these cases is great. This diagnostic study must be comprehensive and complete. It must include meticulous attention to the presenting problems of the patient as well as the family. His job adjustment and prospects as well as his resources or failure of resources in maintaining himself as an active member of his community and his own appraisal of his situation must be realistically understood. The medical examination must be detailed and thorough; it is especially important to know his metabolic status, particularly as to hepatic and cardiovascular function. The presence or absence of brain damage may be critical to an accurate prognosis. A psychiatric diagnosis is necessary and helpful in categorizing the patient and so planning more successfully for his therapy. A diagnosis of his alcoholic behavior should never be neglected. The patient himself should be helped to accept and understand that he is powerless over alcohol and that his

Presented at a Symposium on Alcoholism, Northwest Psychiatric Clinic, Eau Claire, Wis., April 3, 1963.

Doctor Hoff is Professor of Psychiatry and Chairman, Division of Psychiatric Research, Medical College of Virginia; and Medical Director, Division of Alcohol Studies and Rehabilitation, Virginia State Health Department, Richmond, Va.

"The importance of a sound, careful diagnosis in these cases is great. This diagnostic study must be comprehensive and complete."

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life in this regard is unmanageable. The goal of sobriety on a day-to-day basis is in the present state of our knowledge an essential one for successful rehabilitation. It is not, however, the only goal, and sobriety is rather a sign of progressing rehabilitation and becomes a part of a new way of life.

The first problem in the care of the alcoholic is to bring the patient to therapy and help him to continue in a plan of rehabilitation. Often it is not the alcoholic himself or herself who is the first member of the family to seek advice. Sometimes the spouse, a parent, or a child of the alcoholic asks for help first. Rarely the parents but quite often the spouse or children may be provided effective help for their own problems arising out of the patient's alcoholism or out of other family situations or psychologic disturbances. Sometimes such help to the family can be given even though the alcoholic never does come into therapy.

The alcoholic's dilemma arises partly out of the fact that alcoholism overtakes its victim subtly and sometimes imperceptibly. Without quite realizing it or understanding how, the alcoholic may find himself involved in the symptoms of uncontrolled, harmful alcohol use. It is not surprising, therefore, that he often resorts to rationalizations and denial of the reality of his problems. Even when denial is no longer possible he tends to misinterpret his symptoms and misconceive his course of future action. While he may realize that his drinking behavior is causing him more and more difficulty and may be less and less rewarding to him, nevertheless he may be motivated only to try to return to a pattern of some few years back when he felt that he was in control. Thus he may try to cut down his drinking, change his drinking pattern, or avoid drinking when he is angry or depressed.

At this stage, an alcoholic may be quite ambivalent about stopping drinking because, whether or not he recognizes it, alcohol has become for him a necessity without which he cannot function unless his life is drastically changed. Many alcoholics do not clearly recognize what alcohol does for them and will merely say that they drink because they like the effects. Others will assert that alcohol helps them escape from their own sense of isolation and defeat, that it pulls them together when they are panicky, and that it invites them to withdraw into a world of fantasy where they can be for the time being, at least, protected from the pain of living. For some alcoholics, drinking puts them on top of the world and blunts disappointments and failures.

The alcoholic's trouble is that while alcohol acts thus as a psychopharmacologic agent, it is by no means a perfect one. For those who use alcohol to allay serious anxiety or tension or any other severe psychologic or psychosomatic problem, there is inevitable failure. Because of its peculiar actions upon the brain, alcohol relieves severe tension and anxiety only at the expense of serious disturbance of judgment and clouding of mental functions. In this respect, it differs from some modern ataractic agents having a primary action on the limbic system and capable of tranquilizing action without profound sedation. Thus the alcoholic is always in danger of becoming intoxicated by drink and is rendered vulnerable to all kinds of dangers arising out of his drunken behavior. This is precisely what he usually seeks to avoid. Many alcoholics strive to reach an equilibrium in which they feel tranquil and at peace and would like to maintain this state for many hours. Others would like to drink enough to blot out consciousness altogether. Still others express the idea that drinking gives them energy, courage, and motive to get on with their work. For some, a few drinks seem to transform the world around them from a drab, colorless, depressing scene into a new and exciting world of experience which becomes fascinating to explore.

It is no wonder, therefore, that when an alcoholic comes to a clinic or seeks help in any other way, he is saying "yes" and "no" at the same time. He has usually been pressed *ad nauseam* by his family, friends, and circumstances to abandon his drinking but has been appalled by the prospect of an existence without alcohol, since he has been aware of no other technique of dealing with his life. Years without the chemical comfort of alcohol hold out an intolerable future. Nevertheless, when he presents himself for

help, he is really saying that he cannot live with alcohol or without it. By the time he comes for aid, both he and his family are usually at their wits' end. His family may have told him that by the use of will power he should be able to abstain from something that is so clearly harmful to him. The alcoholic himself may accept the idea that his drinking is a weakness, a bad habit which can be controlled through the disciplined exercise of will. He may have tried hard only to have failed repeatedly.

An alcoholic may present himself under a variety of circumstances. His therapist must be resourceful and ready to meet the patient at the level of his immediate felt needs. Drunken patients obviously require a period of withdrawal from alcohol and for this purpose hospitalization is usually best. Some alcoholized patients can be treated at home if the family and physician are willing and able to do this. A patient's first contact with a therapist may come when the patient is perfectly sober but involved in a crisis over a job, an impending divorce, or an involvement with the law. Whatever the presenting situation, the physician will do well to focus upon this with the patient and to begin as soon as possible to organize and mobilize a therapeutic team for the patient and for his family. This may mean bringing into the situation (with the patient's consent) various members of the family, the patient's employer, his clergyman, and such members of the health team as may be needed: psychiatrist, internist, general practitioner, psychologist, social worker, nurse, or others. It is important that no time be wasted. The patient should be seen as soon as possible and unnecessary delays avoided. The patient's

"A patient's first contact with a therapist may come when the patient is perfectly sober but involved in a crisis . . . Whatever the presenting situation, the physician will do well to focus upon this with the patient and to begin as soon as possible to organize and mobilize a therapeutic team for the patient and for his family. This may mean bringing into the situation . . . various members of the family, the patient's employer, his clergyman, and such members of the health team as may be needed: psychiatrist, internist, general practitioner, psychologist, social worker, nurse, or others."

own attempts to delay should be countered by expeditious, helpful planning for handling crisis situations.

Therapy begins at once and the patient should be made to feel that those he has chosen to help him are really concerned for his welfare and that they accept him as a person in need of help and worthy of help. So often because an alcoholic has found himself consciously or unconsciously influenced by prevailing punitive attitudes about alcoholism and alcoholics, he feels rejected, angry, and depressed. A hopeful, resourceful attitude by his therapists can provide a new kind of therapeutic community setting in which he can more quickly accept his real situation and admit that he is a victim of alcoholism without destroying his self respect. If the patient's motivation is simply to handle the immediate drinking crisis or other critical problem, the therapists, by their understanding and helpful attitude, can often deepen and broaden the motivation of the patient towards a new way of life that he never thought could be possible.

Box 174 (19).

CANCER MORTALITY

A unique, long-term record of cancer patients in Connecticut suggests that measuring five-year survival rates obscures an important fact about cancer mortality. In many types of cancer, the patient's chances of approaching or even reaching a normal lifespan increase greatly after the first five years.

That was one of the major implications of the paper Dr. Henry S. Eisenberg, Director of the Connecticut Tumor Registry, delivered before members of the Association of Life Insurance Medical Directors of America at their 72nd annual meeting in New York, in October 1963.

The Connecticut Tumor Registry, Doctor Eisenberg said, is the only U. S. group which bases its studies on a whole population, rather than on reports from selected large hospitals. It has reports on about 165,000 tumors on file, and is now actively following up on some 60,000.

Doctor Eisenberg's statistical evidence dealt with selected types of cancer among women, but he suggested that in varying degrees, depending upon the type of cancer, similar conclusions about long-term survival rates applied to men.

The summary and conclusions of his paper:

"The examination of the long term survival experience of women with different forms of cancer reveals that generally the mortality risk is materially reduced after the first few years following diagnosis. However, this reduction occurs in a variety of ways.

"For example, in cancers of the uterine cervix, the relative survival rate for successive five-year intervals stabilized at 80 to 90 per cent after the first interval, irrespective of disease at diagnosis. In contrast, the mortality risk for metastatic cancers of the breast remained higher than for localized cancers for 20 years after diagnosis and treatment. Furthermore, the survival rates for breast cancer did not stabilize, but increased continuously from one follow-up interval to the next.

"In spite of the upward trend from one follow-up interval to the next, the relative survival rates for breast cancer did not reach the 100 percent level. The mortality risk decreased with follow-up time, but remained at an above normal level for at least 20 years after diagnosis.

"This was not true for patients with cancers of the rectum and intestine. The available data indicate that after approximately ten years, survivors were no longer subject to an above-normal mortality risk.

"The different patterns suggest that different forms of cancer vary with respect to the manner in which treatment affects the course of the disease. For example, the attainment of a 100 percent relative survival rate for cancers of the intestinal tract suggests that some patients were in fact cured. The stabilization of survival rates at the same level for both localized and regional cases, as in cancers of the uterine cervix, suggests that treatment *does* modify the course of the disease, that the nature of the modification is similar in patients with regional metastases as in patients with localized tumors, but that treatment is 'effective' for a smaller proportion of patients with metastases at time of diagnosis.

"The continuing differential in interval survival rates between localized and regional cancers of the breast indicates that the effect of treatment, if any, is different according to the stage of the disease at diagnosis."—NEWS RELEASE by Institute of Life Insurance.

ALCOHOLISM RESEARCH GRANT PROGRAM

Four years ago the Scientific Advisory Council to the Licensed Beverage Industries, Inc. initiated a five-year, $500,000 grant-in-aid program through which small grants, ranging between $2,000 and $10,000, would be made quickly available to competent researchers to undertake preliminary or pilot studies in alcoholism and/or related subjects. A report has been issued by the Scientific Advisory Council which outlines the first three years of this program. Copies are available from the Licensed Beverage Industries, Inc., 155 East 44th Street, New York, N. Y. 10017.

Eau Claire Alcoholism Symposium

Panel Discussion

BY THOMAS P. DETRE, M.D.

New Haven, Connecticut

■ TO MAKE MY position clear about alcoholism and alcoholic patients, I shall assume the role of the devil's advocate and make some random and perhaps evil remarks about the problem.

First of all, alcoholism was not considered a medical problem until a quarter of a century ago. Then we psychiatrists went out on a limb and with a great deal of propaganda successfully sold the idea that alcoholism is not only a medical problem but also a psychiatric problem. Unfortunately, once we had sold our product we were unwilling to buy it ourselves, and we found ourselves not admitting or treating alcoholic patients, but encouraging family physicians to take care of them; and perhaps the information presented at this symposium will do just that.

Now this is pertinent to the whole problem of alcoholism and how it is handled by the patient himself, for it has been very nicely said that an alcoholic is just like any other patient, just like any other person. But as the devil's advocate I would like to promote the idea that at the stage of acute intoxication, after a long period of drinking, he is not like any other patient. In fact, he has some very particular skills which he can and does use to achieve his desired end results.

For example, an alcoholic, who has been a patient of yours before, comes to your office and asks for help. He tells you that he has been drinking, not excessively, but a little too much, and he would like to undertake treatment. You volunteer—sign a verbal contract—and tell him you are going to take care of him, to examine him very carefully, to evaluate his nutritional status, and so on.

You give him an appointment for a parenteral vitamin-B injection at 9:30 Monday morning and the patient leaves with a big smile on his face, a charming smile, a friendly smile. On Monday he arrives at 10:15 instead of 9:30 and tells you that he wouldn't be at all surprised if you refuse to see him or give him his injection because he's late. So you chat with him, and of course you can understand why he was late; after all, he's just a poor devil who is suffering. You usher him into your office and devote an hour or so to talking, giving him his injection and listening to his troubles while your other patients wait. But you have saved the day for him and you feel very good because he's grateful. He shakes your hand and says, "Thank you, you've done a great deal for me." The next morning at 6 o'clock you get a telephone call, and the patient says, "Doc, I'm stinking drunk, how am I going to go to work now?" So you get out of bed; go to his home; reassure his wife; give him an injection—whether it helps or not—and things are looking bright again. At 8 o'clock he manages to roll into work and everybody's saved.

You continue to do this with great pride until about the umpteenth time, and then your patient catches you at the wrong moment. It's 9 o'clock in the evening and you have dinner guests. He telephones and says he needs you; he's really in trouble with impending delirium tremens. But no matter what happens, you're not going to go. You tell him it's the wrong time to call, that he should stop drinking, that he does not have the proper attitude. In other words, you blow your top, moralizing of course, but you still blow your top. What happens? Your patient goes into delirium tremens; his wife is exasperated; you gain a fantastically good community reputation; and you never want to see him again.

So I suggest that this is a very difficult contract, and I do not share the optimism of some of my colleagues. I do think the contract can be fulfilled on both sides only if the physician maintains a consistent attitude. For example, if I give an appointment at 9:30 in the morning and my patient shows up at 10 o'clock, I tell him to come back a

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Presented at a Symposium on Alcoholism, Northwest Psychiatric Clinic, Eau Claire, Wis., April 3, 1963.

Doctor Detre is Associate Professor of Psychiatry and Chief, Psychiatric Inpatient Division, Yale University School of Medicine, New Haven, Conn.

week later and to remember that the appointment is at 9:30. Believe me, I am not any nastier than others, but I simply don't want to lose my patience. I would like to be of some service to him, but I cannot underwrite a contract without cooperation on his part. Furthermore, my patient probably would agree with me. He and I would also agree that an alcoholic patient does not have much respect for a physician he can outmanipulate any time he decides to do so. By the way, manipulation of this kind is not a characteristic of the particular person, it is the particular characteristic of addictive patients, not only alcoholic addicts but also addicts per se.

We have heard many fine definitions here, especially of an addicted person and what addiction means. I prefer the British one because it contains no moralistic statement. The British merely say a person is an addict to a drug when he feels normal on that drug, whatever it is. So the beginning of a contract is to understand that you are going to undertake treatment of a patient who feels normal only when he is on a drug, and the first friendly gesture is to say to him, "Look, Bud, you're going to have to leave that drug, you can no longer use it." It is quite obvious that in spite of his good will, or what appears to be good will, you will have a very, very difficult time.

"Long-term hospitalizations, especially when enforced, do not do much good . . . The longest time for alcoholics to be kept in our hospital is usually about three weeks."

I don't know of any good psychiatric studies that have demonstrated the presence of special personality differences in alcoholic patients. I think any one of us in this room could become an addict provided two conditions were met: no more social drinking and an opportunity to experience alcohol at a time of major social or personal stress. Under these conditions, any of us might qualify because this magnificent drug is capable of providing us with serenity. This is something alcoholics are looking for, and it must be understood that when treatment is started, serenity will be nonexistent for the patient for the next five years, for when he is sober, serenity is not secure. That is why I agree with Doctor Hoff, whose paper also appears in this issue, that in many instances, in spite of the possible dangers, sedative treatment of some sort is indicated.

There are really only four reasons why a patient drinks: (1) because he's alone, (2) because he's in company, (3) because he is happy, and (4) because he's distressed. There are no other reasons. I am not joking. There is a general state of sensitivity to anything which disturbs the patient's general comfort. That is, no disturbance is tolerated by the addict, and the troublesome aspect of the problem is that alcohol is a magnificent drug, especially for his purposes.

I agree with all that has been said about drugs and yet I have very bad news for you. Two ounces of whiskey to a tremulous, desperate alcoholic patient is a lifesaving measure, better than any other drug and faster. The real reason we do not give it is that we moralize about it, not because it is not an effective drug.

PANEL DISCUSSION

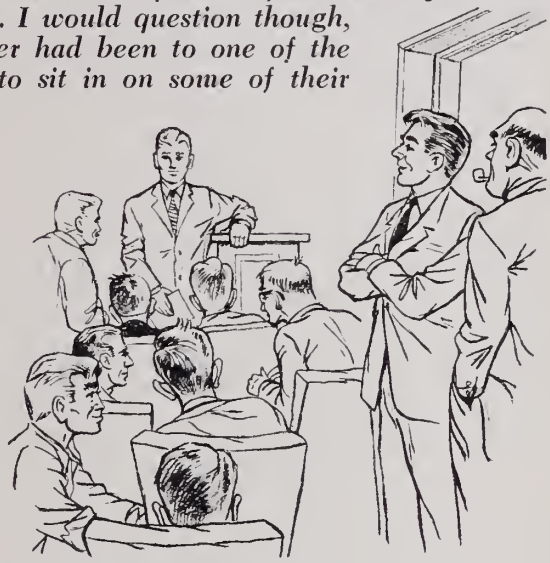
Question. For those going through this long, drawn out struggle, which is better: short periods or longer, forced periods of hospitalization?

Dr. Ebbe C. Hoff: I don't think you can set any general rule. We have tended to favor a shorter time, say a week or two, since there are obvious disadvantages to long hospitalization. The patient, for example, may lose his job, or he may acquire certain dependencies in the hospital that may not be therapeutic. On the other hand, I think there are some patients who will do well with longer hospitalization.

Dr. Joseph F. Chambers: In a clinic setting, where you have a motivated patient, one who has some understanding of what is going on, a shorter hospitalization may well do the trick. But where you have personal disorientation or profound alcoholism with possible early brain or liver damage, I think these patients desperately need longer hospitalization, enforced if necessary.

Dr. Joseph B. Kendis: Long-term hospitalizations, especially when enforced, do not do much good. In addition to dependency, loss of job, and the like, there develops this tremendous wall between the patient and the outside world. Also, these alcoholics notably

"I think the position of the people in Alcoholics Anonymous is very clear. They call us their friends and I think most of them mean it. But there is also a kind of smugness about them that says in a sense: no one can treat an alcoholic but a fellow alcoholic. I think what they really mean is: no one can empathize quite the way another alcoholic can, but we still need you, doc . . . I would question though, how you could understand A.A. if you never had been to one of the meetings . . . I think it's quite refreshing to sit in on some of their meetings and see what goes on."



do extremely well while in an institution, and the idea is to try and promote some way of getting them out and to work in the community. The hospitalization time will vary depending upon the degree of physical and mental damage.

Dr. Martin D. Kissen: I agree, very definitely. I can't see where the extremely long, enforced hospitalization will be of value. I think a patient should be hospitalized just long enough to get him "de-alcoholized" and thinking straight again, and then followed up with outpatient treatment. The longest time for alcoholics to be kept in our hospital is usually about 3 weeks, once in awhile 4 or 5 weeks. This is a sort of cooperative thing with the patient, and after he is over that first week or two, he knows he needs a little more and will cooperate.

Dr. Thomas P. Detre: The only thing I could add is that an adjustment of family and work situations is mandatory before discharge. No patient should be allowed to leave the hospital unless and until the employer takes him back to work, and until the family has had sufficient rest from him. Sometimes the reason for hospitalization is not the alcoholism itself, but the family's and employer's inability to tolerate the patient in an intoxicated condition. After these factors have been straightened out, I think he can be discharged.

Question. The members of Alcoholics Anonymous seem to feel that an individual cannot understand the language of the alcoholic unless he has been an alcoholic himself. Do you agree?

Doctor Detre: That is, of course, a very difficult question because it is most important to realize that people who have been crippled by some kind of illness are both very dependent upon us and at the same time do their best to reject any feelings of dependency. The patient's occasional statement, "I don't want you and I don't need you," is not meant to be taken literally. It doesn't necessarily mean they want us to desert them. I would be very much surprised if Alcoholics Anonymous would prefer to operate without our presence in the picture.

Doctor Chambers: I think the position of the people in A.A. is very clear. They call us their friends and I think most of them mean it. But there is also a kind of smugness about some of them that says, in a sense, no one can treat an alcoholic but a fellow alcoholic. I think what they really mean is: "No one can empathize quite the way another alcoholic can, but we still need you, doc."

Dr. Jackson Smith:* Let me say this. I don't think it requires a chronic smoker to understand someone else who smokes, to understand the mechanism, and the same with drinking. I would question though, how you could understand A.A. if you never had been to one of the meetings. It's encouraging that they discovered group therapy as early as 1938. Psychiatry didn't make it legitimate until around 1958, but we saw the light. I think it's quite refreshing to sit in on some of their meetings and see what goes on.

* Doctor Smith is Clinical Director, Illinois State Psychiatric Institute, Chicago, Ill.

Doctor Hoff: In a certain sense it is very difficult for any of us to understand anybody else though we work at it, and in this sense I think the members of A.A. are, to a degree, right. The physician does not have a full understanding of their problem unless he has been through it himself. But sometimes he can associate with a patient because, while he may not have had that particular problem, he has had other problems of his own. Although a recovering alcoholic in A.A. may not think too highly of physicians, there is always the beloved exception, which means there are several beloved physicians, and this is good. Another thing: if you ask an alcoholic how he recovered, he can't quite say, and that's true of A.A. members too. The most I can get out of my old patients is that they just stopped to think, they "paused enough," or something like that, and nothing much more than that.

Doctor Smith: I agree. This may be a mystical experience, and I don't think that's too bad a term. If it is felt totally, there is no need for any other help; and I think some people feel it to this degree. In fact, it can be detrimental to the patient if someone who recently joined A.A. and feels very strongly about it tells him, "You don't need anything else, this is the answer, this is all of it," because this "answer" depends to some extent upon the mystical experience.

Doctor Kendis: I agree in large part with the panel and would like to go a step further. I think that whether or not we understand the patient because we have or have not been there is beside the point. If we can help him, we're gaining something and he's gaining something. Here I would suggest that all physicians find out more about A.A. and that they read the big book of A.A., read it and study it thoroughly. There are many things in it besides alcoholism.

Doctor Detre: If I may interrupt for a moment, I don't think reading the book is as useful as going to some of the meetings.

Doctor Kendis: That's true.

Doctor Detre: Unquestionably, they can do something we cannot do; that is, hold the patient's hand for several hours or days through a period of extreme need. This is a great service which needs to be appreciated.

Doctor Kendis: I think a lot of the difficulty arises from the fact that for a great many years, unfortunately, the people who are now in A.A. came up against physicians who had no understanding, no desire to help, didn't want to be bothered with the problem. This produced a feeling that the physician was in his own little world and knew nothing about the A.A.'s world. But today there are many more among the newer A.A. people who avail themselves of the physician's services, and there are more physicians who understand the problem and want to help.

Doctor Detre: Perhaps the nearest we can come to it is a revelation to the patient that he must stop, he must not be selfish, that the physician and every other member of his society wants this for the patient's own protection; and all of it will suddenly begin to make sense. It is very hard to describe the dynamics of this, and I don't know of anyone who has successfully attempted it. Certainly I am in no position to do so. I think it's a nonrational experience and that it is almost senseless to try to get a patient to tell us what it involves.

Doctor Chambers: I would like to make one observation here. I think a change in a patient's approach may be something, but perhaps it is more often a gradual transition. Somehow or another a patient is able to expose himself to people who are going to be critical of his feeling. The people in A.A. want him to change, and at the same time, he himself wants to change. If not exactly wanting to, he begins to be somewhat open-minded about this. Placing himself with these A.A. people, he begins to develop a change in outlook and attitude over a period of a few months. I think perhaps this happens with our alcoholics over a period of time, a gradual transition, although we perceive it as sort of sudden.

Question. In bringing about this change, gradual or sudden, what is the value and procedure of psychotherapy as a special technique?

Doctor Smith: This, of course, is a key question. We repeatedly insist, request, and advise that the generalist, all nonpsychiatrists in a position to treat these people, employ psychotherapy. But what is psychotherapy and how do you use it? A cogent comment on this was made by a California physician. He said that he's always attending lectures where he's told that psychotherapy can't be explained to him in a lecture, but it would be nice if he could spend

six months in a seminar on the subject. His complaint is: where is he going to find the six months? I think we should attempt to define what we mean by psychotherapy, and where and how it can be practiced. What about the man in private practice, how should he proceed?

Doctor Detre: Well, I have a very simple working formula for this. If we invite the patient and his important relatives to a meeting—and sometimes this includes the mother, in spite of the fact that the patient is married—and sit down in a room with them, at least we give the meeting dignity and a professional setting in which the family can discuss some of its problems, especially if we don't interrupt them by preaching.

Doctor Hoff: Just one comment on what Doctor Detre has said and that is about the five-year period I spoke about earlier. What Doctor Detre describes is sort of a six-month stage. There is something like that for the first six or nine months of a year and a patient will then say that he can really understand things better than he did. So this first year is the time when one has to be supportive of the patient and alert to what is happening; and I would agree that so-called intensive psychotherapy at this time may be useless and damaging. After that time, if anyone has won a battle, it is the patient, and then one can explore other approaches, including psychotherapy, and these may have to be determined on an individual basis.

Doctor Kissen: In Philadelphia we have a total outpatient clinic, that is, there is no inpatient facility connected with it. It is run by the combined efforts of the city and the State Health Department. We have found that our patients can dry out without hospitalization because there is no place for them to dry out in the setup we have. In what we call our physical or organic services, we give them shots of vitamins and tranquilizers if necessary, and they are seen by a physician once or twice a week. Then we have mental health services which include individual and group psychotherapy, and we have rehabilitative services which utilize all the forces in the community to help these people, who come mainly from the lower economic levels, get back on their feet. We talk with them, give them as much support as we can, and work with them to the extent of trying to fill their needs. After about six or seven months they will ask to see the psychiatrist or social worker with a view toward entering some kind of psychotherapeutic relationship, or at least some group psychotherapy. In short, we wait until the patient makes known his wishes, and it works out much better that way. You can't force the patient into a psychotherapeutic relationship.

"Alcoholism is a family disease. To be successful in treatment it is necessary to look beyond the alcoholic himself . . . Alcoholism is a disease affecting all communities, and communities must be awakened to their responsibility in the overall treatment of this disease. They must be informed; they must be educated; they must help in the control and treatment of alcoholism."

Doctor Smith: Well, if the physician will just tolerate what he hears, I don't think he'll be upsetting to the patient. I don't think it matters so much what you say—it is better to say very little, of course, but it's how you respond to what you hear that's important. If it doesn't disturb you, it won't disturb the patient. The worst possible thing is to say: "Let me tell you what I think." We all know that the most interesting advice you can take is your own, but I don't think you

"The first problem in the care of the alcoholic is to bring the patient to therapy and help him to continue in a plan of rehabilitation . . . Therapy begins at once and the patient should be made to feel that those he has chosen to help him are really concerned for his welfare and that they accept him as a person in need of help and worthy of help . . . The use of tranquilizing drugs has brought about a vast change in treatment."

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should give it to the patient. There is a tendency to say to him, "Why don't you do as I do?". This is quite prevalent among psychiatric residents. I would like to hear a discussion of the treatment of the acute phase of alcoholism at home.

Doctor Kissen: Well, most of us have mentioned that we would prefer to start therapy in a hospital setting, but in many cases because of economic difficulty, location or the absence of facilities in a general hospital, they have to be treated at home.

A Patient: Doctor Chambers mentioned certain criteria that had to be met and these should all be borne in mind when you start to treat a patient at home. First of all, the patients start with the precept that they are going to stop drinking immediately, they don't believe in this tapering off business. But at home a patient has much more access to drink than he has in a hospital setting, and you must see that he doesn't get any. Usually, it's a very important policy to have someone stay with the patient for at least the first 48 hours, and when I say stay with him I mean constantly, day and night. Incidentally, this is where A.A. can be very helpful because they will set up teams in relays to stay with a patient providing he tells them he wants help. But you can't force the issue, you can't do this on the word of the woman who calls you up to get something to put into her husband's coffee to make him stop drinking. It doesn't work that way. A.A. is willing to cooperate and do a great many things to help, but only if they feel the patient himself sincerely wants to do something about the problem.

Doctor Kissen: With these things in mind, it's just as easy to treat a patient in the home as in the hospital if you have confidence in the people who are with him, and it does save money. Of course you can't get intravenous fluids, but you certainly can force fluids by mouth, you can provide him with injections that are indicated, and you can use chlordiazepoxide (Librium) in doses of 100 mg. if necessary, providing there is someone to stay with him. This does require more of your time: you will have to visit the patient at least once a day, and sometimes twice on the first day, to make sure things are going along fine, but it would seem to be worthwhile.

Doctor Hoff: I'm going to add one thing. If I should get a call asking what can be done at home for someone who can't possibly go to the hospital, my first question would be: Does the patient want treatment? If the patient himself does not want treatment, you are going to have a rough time at home. I think that chlordiazepoxide and vitamins, both by injection and orally, as mentioned by Doctor Kissen, are required. I think another thing that helps at home, besides the orange juice I mentioned earlier, is to get the patient into not a hot, but a warm tub. Perhaps I'm going back to the old therapy, but if the patient can soak in a warm tub with a magazine or a newspaper, he'll find that this will relax him.

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333 Cedar Street.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Drug Reactions after Ingestion of Alcohol

By JOSEPH J. BARBORIAK, Ph.D.
Milwaukee, Wisconsin

■ ONE OF THE relatively little explored pharmacological effects of ethyl alcohol is its ability to produce undesirable reactions when taken during medication with certain drugs. The incidence of such reactions is bound to rise, since some of the "reactive" drugs, such as the hypoglycemic sulfonylurea compounds and some tranquilizers, are used on a long-term basis in an increasing number of patients. Although a large number of agents were reported by Buttner,[1] to give reactions with alcohol, only some of the more common drugs will be discussed in the present report.

1. Hypoglycemic sulfonylureas. Side effects after ingestion of alcohol were reported in about 10 to 20 per cent of patients taking the oral hypoglycemic preparations. They seem to be somewhat more frequent with chlorpropamide than with tolbutamide or carbutamide.[2] The symptoms consist of flushes, intense feeling of facial warmth sometimes spreading to the trunk, headache and a feeling of breathlessness. These effects appear 3 to 10 minutes even after taking small amounts of alcohol in combination with the sulfonylureas. The side effects usually last for one hour or more. Similar symptoms are present during the treatment of chronic alcoholism with tetraethylthiuram disulfide (Antabuse) as well as in the carcinoid syndrome. However, neither the elevated blood acetaldehyde levels, believed to be responsible for the hot flushes during tetraethylthiuram disulfide therapy nor the increased urinary secretion of 5-hydroxyindoleacetic acid seen in carcinoid syndrome, could be demonstrated in the reactive patients on hypoglycemic drugs.[2] A switch in the type of sulfonylurea, or taking oral antihistaminics one hour before administration of the hypoglycemic preparation was reported to alleviate the post-alcohol reaction.[3] It is worth mentioning that somewhat less annoying side effects were observed in patients treated with phenethylbiguanide.[4] The alcoholic beverages seemed to acquire an unpleasant metallic taste and most of the patients voluntarily gave up alcohol. Because of the post-alcoholic side effects, sulfonylureas and phenethylbiguanides are being considered as possible alternatives to tetraethylthiuram disulfide for treatment of chronic alcoholism.

2. Tranquilizers. Alcohol potentiates the depressant activity of some tranquilizers on the central nervous system. In a clinical study, a small amount of alcohol taken during chlorpromazine therapy significantly impaired the performance and coordination of the test subjects. In most of the subjects a given dose of alcohol was judged to be more intoxicating when taken with chlorpromazine than when taken alone.[5] Possibly chlorpromazine interfered with the metabolic removal of alcohol from the circulation.[6] It is of interest that subjects receiving meprobamate, considered to be a less potent tranquilizer than chlorpromazine, showed a more pronounced impairment of judgment and performance after alcohol than those treated with chlorpromazine.[7] Since large numbers of persons taking meprobamate also drink alcoholic beverages and then drive automobiles, it is important to warn them about the possible dangerous effects of the alcohol-meprobamate combination. Several of the ataractic and analgesic drugs were tested in animal experiments and they showed the following order of potentiation by alcohol: reserpine > chlor-

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promazine > d-propoxyphene = morphine > meprobamate = phenaglycodol.[8] In clinical studies with chlordiazepoxide[9, 10] and diazepam,[11] alcohol had no significant effect on the emotional state or performance of the subjects.

3. Barbiturates. As with the tranquilizers, alcohol potentiates the central nervous system depressant activity of barbiturates; however, with much more serious sequences. Several deaths were reported in alcohol intoxicated patients taking relatively small amounts of barbiturates.[12, 13] The severity of reactions after barbiturates seems to be related to the concentration of blood alcohol and the results are, therefore, more serious in drinkers of spirits than in the beer drinkers.[14]

4. Anticoagulants. Alcohol was reported to increase prothrombin levels.[15] Excessive drinking, as well as fluctuation in alcohol intake, changes the amount of anticoagulant needed for effective control of blood coagulation.[16]

5. Insulin. In some instances, alcohol was reported to reduce the requirement for insulin, probably by supplying energy from a source which is not dependent on insulin-regulated processes.[17] In some countries wine is regularly used in the diet of diabetics.[18] However, if these patients are transferred from insulin to oral hypoglycemic drugs, many of them develop the facial flush as described previously.

In at least one disease, ingestion of alcohol alone causes occasionally serious reactions. In some patients with *Hodgkin's disease,* alcohol produces painful reactions, enlargement of the affected lymph nodes, general malaise, dyspnea and palpitation.[19] The underlying mechanism is not known.

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. . . IT IS EVIDENT THAT the way physicians see alcoholism exerts a tremendous influence on the way alcoholics are treated. The physician can serve as a case finder of alcoholics; yet until physician attitudes and knowledge about alcoholism undergo change, many alcoholics and prealcoholics will not receive treatment until the disease is so far advanced that treatment becomes highly complicated, therapeutic goals limited, and necessary resources extremely expensive. — HOWARD T. BLANE, Ph. D., WILLIS F. OVERTON, JR., M.A. and MORRIS E. CHAFETZ, M.D.: Social Factors in the Diagnosis of Alcoholism, Quarterly Jrl. of Studies on Alcohol, Vol. 24:640–663 (Dec) 1963.

THE PRESIDENT'S PAGE . . .

Social Scientists and Physicians

■ HURRAH! For me, during this very pleasant presidential year, the most arduous task has been preparing these editorials. I am deeply grateful to our Mrs. Angell and her associates for their most gracious and helpful assistance. So, here goes with the final challenge.

So many of us have been so assiduously busy maintaining and improving the status of our State Medical Society that we have neglected either a discussion or a formal study of the party of the second part; namely, the citizenry with whom we practice medicine. What kind of people are they? What are their philosophies, habits, behavioral characteristics, educational status, spiritual status, and the like? How does the present day patient compare with the "old-fashioned family physician's patients?"

We have personal contact with thousands of patients and citizens daily. We are historically cognizant and personally familiar with the virtues and vices as well as the possible cruelty of mankind. So much so, that humility is one of the dominant traits in a superior physician. And we believe in work and action rather than in quantitative moralizing.

A study of our citizenry, carried through in true research methodology, might be helpful and exceedingly interesting to our patients and to us. If ever undertaken, this study should be conducted by those who are scholarly, and having common sense will be familiar with the virtues, follies, and foibles of humans—as well as be on the lookout for "blind spots."

For over two years I have been collecting material in the above area. The file, labeled "moral climate," has already grown formidable in size.

Two recent developments may be of interest to our members and to our Society itself.

First, a survey made among over 400 political scientists has announced that the political science department of the University of Wisconsin is rated among the eleven "best" in the nation. Also, evidence suggests "that there are no prestige political science departments except at prestige schools." This source should interest physicians who are neither extremists in conservatism or liberalism. Many prefer to be "moderates."

continued on page 216

PRESIDENT'S PAGE *continued from page 215*

Also, those who are concerned about the extremism, violence, hatreds, propagandized distortions, and misuse of facts in political campaigns may be interested.

The second event of interest to all of us is the establishment of a new home for the University's Institute for Social Research at Ann Arbor, Michigan. The Institute is a national leader in the study of man and society, and has earned an international reputation for the application of both scientific measurements and theory development to human problems. Director Professor Rensis Likert points out that the new arrangements "readily provide the opportunity for stimulating interaction which our research shows is so necessary for high creativity on the part of the research staff."

The two main divisions are the Survey Research Center and the Research Center for Group Dynamics. Units within these two centers regularly conduct research and study programs in critical areas such as children, youth, family life, and mental health in industry; and in other areas such as economic behavior, leadership and organizational behavior, student development, mental health, public communication and influence, group communication, analysis of social power, effects of group membership, group performance, and theory and method of planned change.

The Institute has a powerful instrument, to sample mood and opinion, in its staff of some 250 trained interviewers across the nation. Beyond its unique contribution toward the understanding of human nature and society, the Institute is actively training educators, scholars and statisticians in order to expand this for human betterment.

Research and careful study in this area will assist us in practice and particularly in our roles as citizens. It will help in handling those pressure groups who, with impetuosity, act on outrageous assumptions and attempt to force momentous changes into one or two generations of people. It will be of great assistance to those of us who wish to develop or confirm value judgments in human relations.

In discussions of the crises and problems in the complex field of human illness, diagnosis, treatment, and prevention are always in the foreground. But recently a new term, "moral gap," has appeared. It encompasses the tremendous difference between what we profess and what we have done; and what it is that we stand for and what we have "been able to make a reality."

Capable management and real team work will provide the means to accomplish our dedicated aims, for the essential leadership will be established. But, being humble with no vestige of selfishness, intelligence, with decisiveness, knowledge and skills for performance are not the most important factors. The number one requisite—vitally important—is the ability to get along with other people.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

APRIL 1964

Vol. 63 No. 4

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Onward and Upward

■ THE ASSOCIATION OF American Medical Colleges reports that the recent downward trend of the number of applicants for medical schools has been reversed and that the rate of increase in the number of applicants is substantially greater than the rate of decrease noted in the eight years prior to 1962.

The fact that fewer qualified young people were indicating an interest in the medical profession had become of such concern that the federal government announced plans for financial assistance to prospective medical students, as part of its overall health care program. The existing shortage of doctors in many areas appeared to be heading toward the critical stage, and, indeed, the adequacy of any national health care program seemed threatened.

When the trend became definite, the American Academy of General Practice instituted its "Project MORE." Designed to interest young people in medicine as a profession, it sought to recruit those qualified students who could be considered as legitimate prospects for medical schools. The project was vigorously implemented, and the happy news from the medical schools is evidence of its success.

As the number of students taking the medical college admissions tests increases—reportedly up 38 per cent from the classes starting in 1960 to those starting in 1964—the American Academy can congratulate itself on a job well done. While the higher birth rate beginning in 1940 and more available financial aid played important roles in the increases, the effective recruitment program sponsored by the Academy unquestionably fused the social and economic factors into a positive result.

The entire medical profession owes a debt of gratitude to the American Academy of General Practice for "Project MORE." —D.N.G.

Pharmaceutical Piracy

ONE OF THE happier manifestations of the cosmopolitanism abroad in the world today is the growing spirit of commercial enterprise in formerly non-industrial countries. In the medical field, we have learned about the book publishing business in Formosa which is able to reproduce high-priced medical books and sell them at a fraction of the price that legitimate publishers must charge. Of course, the Formosans do so in violation of international copyright laws and without compensating the authors of the books for their effort, but such piracy harms only the few persons whose property rights are concerned.

Of much more seriousness, however, is the kind of commercial piracy that involves public health. Recently the New York Supreme Court ruled that a former employee of a leading pharmaceutical manufacturer had stolen drug production information and antibiotic cultures, and sold them to several foreign drug firms. These foreign firms, presumably, manufactured the drugs and shipped them into the United States in competition with the original developer and manufacturer of the drug. Since the foreign manufacturers have not sustained any development costs—unless one classifies the cost of piracy as a development expense—the foreign drugs are sold for much less than the product distributed by the original manufacturer. Additionally, without the necessity of maintenance of high standards of quality control common to the pharmaceutical industry in this country, the ultimate price of a foreign-made drug can be further reduced.

Doctors often receive circulars from drug jobbers listing pharmaceuticals of all types at prices considerably lower than what is being charged for equivalent products made by known firms of good reputation. Sometimes the price differential is even more startling than that which the Kefauver committee encountered. The drug jobbers offering such merchandise use all the tried-and-true devices of sales promotion, such as "free" merchandise with orders of $20.00 or more, "premiums," and the like. Frequently they require cash-with-order in case you change your mind or don't like what you receive.

While nobody objects to saving money by buying pharmaceuticals at a lower cost, such economies should be viewed in the light of the risk resulting from using a drug product of unknown manufacture. Unlike a poorly made camera or transistor radio, an improperly produced pharmaceutical can lead to medical mishap or even fatality. And while the federal labeling laws provide some protection, the assurance isn't complete that what comes from an unknown source is of dependable quality. Furthermore, widespread use of low-cost drugs from foreign sources made from purloined cultures or by stolen processes unquestionably makes a mockery of the protection of United States laws.

As doctors have the responsibility of knowing what drugs they administer to their patients, so they have the responsibility of knowing that those drugs are from a high quality source. To do otherwise is to jeopardize the health of the patient as well as to help destroy the domestic pharmaceutical industry that has served the American medical profession so well. —D.N.G.

Sword and Buckler: Part I

Reprinted with permission from the NEW YORK STATE JOURNAL OF MEDICINE, January 15, 1964

A RECENTLY reported experience with a pay telephone points up a common human weakness. A person had completed a call, but the operator inadvertently refunded his dime. As he was saying "good-by," she broke into the conversation and asked that he redeposit the ten cents in the coin box. "I'm sorry," he answered, mimicking the operator's tone, "I cannot do that, but if you will give me your name and address I'll be happy to mail it to you."

None who heard the story questioned its veracity. True or not, all laughed, and with some glee, because this response reflected a desire that most of us have to strike back at a huge, shapeless, impersonal institution.

The telephone company seems always to have the upper hand in its dealings with us. We remembered the times when an operator had offered the same reply in answer to our overdeposits, and we were happy to see the company get a taste of its own medicine.

Housewives who acquiesce when the supermarket clerk misses a five-cent item at the checkout counter have something of the same feeling. The large impersonal grocery chain has been earning millions every year from their patronage—and that of others like them—and they accept readily what appears to be a clear challenge to "put something over" on the store. After all, they seem to reason, we're not hurting any one in particular. No children will go hungry because of the loss of this nickel item. And they rationalize their virtue: They wouldn't think of taking anything from the corner grocery store when a real person, one whom they can see and talk to, would be hurt.

Cheating or exaggerating a little on income tax returns has become so common that jokes on the subject aren't even funny any more. Most people who delight in saving a little money at the expense of the impersonal "government" do not apply the same moral code to all their personal and business dealings. If they did, all form of order would disappear from society.

Insurance ranks directly next to government in bigness, rigidity, and impersonality. If we fudge a little on a life insurance or casualty company or Blue Shield, whom are we hurting? Not our patients; we wouldn't cheat them. In what appears to be the only way we can, we're only getting back at the large organization that has dealt impersonally and rigidly with us.

Perhaps we all take out our feelings of hostility on some large, gray, unknown agency, some choosing the government, some the supermarket, and others, Blue Shield. If a physician reports a procedure a little different from the one he actually performed on a patient, an astute psychiatrist might say he is retaliating for the shiny bicycle his brother received on a birthday fifty years ago when the physician himself received only a new suit of clothes. Many who are trained and skilled in probing the hidden motivations of the human mind could discuss this question at great length and reach more valid conclusions—or perhaps reach none at all other than that man's greed for money is the sole cause.

Laymen in affairs of the mind don't know why it's done, but the venality of a very, very few shames us all. It is known that in a variety of ways these insidious few are cheating Blue Shield to the tune of many thousands of dollars each year. There is no question that it is being done; the only question lies in determining what to do about it—how to stop it. The means available for stopping it are basically the same that are available in any law enforcement situation. The only difference lies in the fact that we as a profession are given first crack at policing it—and that is important because we have much to gain in keeping the means of law enforcement within our own ranks rather than surrendering it completely to public agencies.

What are some of the offenses?

1. An ophthalmologist submitted 170 claims for removal of a foreign body from the cornea during the course of a year. In reality, the services in these cases were limited to medical examination and treatment of the eyes. No foreign bodies were present or removed.

2. A general practitioner submitted 157 claims for incision and drainage of carbuncles during a six-month period. It developed that the lesions were pustules, furuncles, or small subcutaneous abscesses rather than carbuncles.

3. A dermatologist reported removal of a breast tumor which on further investigation turned out to be the removal of a benign skin lesion located on the breast.

4. A general practitioner during a six-month period submitted eight claims for reduction of dislocations of major joints in his office without the use of x-rays.

Blue Shield may be a large, impersonal institution to some, but every dollar that it pays out on exaggerated, padded, or fraudulent claims like these will eventually be made up at the expense of every one of its 5 million plus subscribers in the New York City area, over 7 million throughout the State of New York, and 50 million in the nation. When excessive funds are paid out, either benefits must be cut or rates must be raised—there are no two ways about it. There will be no alternative of cutting stockholders' dividends, because there are no stockholders and no dividends. There will be

no decline in profits, because no profit is sought or earned by Blue Shield. It is our own neighbors—our patients—who must ultimately pay. And when they pay, we pay, too.

These abuses, or what Blue Shield and the insurance companies call "overutilization," fall into four categories of severity. The first two are considered "illegal abuse" and the last two, "legal abuse":

1. Outright fraud, such as reporting and receiving payment for services which were never rendered. This, of course, is the most severe form of abuse.

2. Questionable fraud, such as reporting a service of greater scope than was actually rendered or reporting a covered service in lieu of an uncovered one to receive payment under the subscriber's contract.

3. Excessive utilization, such as rendering services repetitively and selectively on successive patients to obtain money available through insurance coverage.

4. Questionable excessive utilization, such as performing an eligible service, considered acceptable medical practice but not consistent with the injury or illness, to obtain reimbursement for a service not covered under the subscriber's contract.

The various forms of abuse may differ in severity; they may differ in difficulty of detection; they may differ in means of handling once detected. Some may be recognized as crimes by public statute, while others may not be. But they are all forms of cheating the insurance company, and we all have a stake in stamping them out.

What can we do about it? As has been noted, the means available are the same as for any type of policing action: detection, elimination, and prevention.

Who Is Responsible? . . . COMMENTS FROM THE PRESS

In testifying before the House Ways and Means Committee in favor of the administration backed plan of medical care through Social Security, Dr. Benjamin Spock said that it would help youngsters as well as the elderly and seriously ill. Families that must spend large amounts upon unexpected illness often then are unable to provide their children with higher educational opportunities, according to the baby specialist.

But we must begin to wonder just how high deductions from income can become before more and more Americans must turn to government programs for all sorts of things they formerly tried to take care of themselves.

Is it necessarily dreadful if healthy young people find they must work a little harder to provide for those who are old and who have in the past worked quite hard for them? The costs of education are high and will certainly go higher in the inflationary spiral and as competition for higher education becomes tougher. But there are scholarships and loans available. And some educators are beginning to feel that scholarships based entirely on need tend to discriminate against the family which has felt the importance of a higher education enough to set aside funds for it.

Other testimony on the medical aid plans indicates that there are no sound and solid statistics to show just how much Medicare will cost in the future. Advocates of the Social Security deductions at first said they would amount to about 25 cents per week per worker. But the matter of rising hospital costs was overlooked because, as one expert said, "we just weren't smart enough at the start." The difference in hospital costs since the project was first broached and 1965 has already brought the 25 cents per week up to 28 cents per week or $13 a year to $14.56.

Chairman Mills points out that hospital costs have been rising the last few years more than twice as fast as have wages. While this makes the blow of serious illness even more stunning to any family, it doesn't help the proposal of deducting costs through Social Security either. In fact, if the trend continues, the cost of hospital care in 50 years would be $1.178 per day while the average daily wage would be only $88! This is obviously impossible but it is not likely that hospital costs will level off very much in the next few years.

Social Security deductions, which began at 2 per cent, are now at 7¼ per cent. They are scheduled to climb to 9½ per cent by 1968 so as to take care of the rising costs of disability and retirement programs. And every time Congress has sought to reduce the impact upon the low wage earner by raising the base for deductions, it has also widened coverage.

We think American families should have the opportunity to decide for themselves whether they should save their money for college opportunities or for big medical expenses. As Dr. Spock well recognizes, one of the biggest problems in raising children is teaching them responsibility for their actions. And yet the government more and more is taking away that responsibility—Reprinted from the *Green Bay Press–Gazette*, Feb. 12, 1964.

Minutes of Council Meeting

MADISON, OCTOBER 17, 1963

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 8:00 p.m. on Thursday, Oct. 17, 1963, at Society headquarters in Madison. All voting members of the Council except Doctors Bell and Chojnacki were present, including Past President Hill, President Egan, and Speaker Callan. Others present were President-elect Curran, Vice-speaker Carey, AMA Delegates Bernhart, Galasinski, and Quisling; Doctor Picard, alternate delegate to the AMA; Doctor Simenstad, AMA Trustee; Doctors Twohig and Mauthe, Fond du Lac; Messrs. Crownhart, Toser, Murphy, White, Hansen; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes

On motion of Doctors Blanchard-Mason, carried, minutes of the July meeting were approved.

3. Oath of Office

The oath of office was administered to C. W. Stoops, M.D., Third District Councilor, by Chairman Fox.

4. Report of Planning Committee

Minutes of the committee's September 28 meeting were presented to the Council, with action on various recommendations as indicated:

a. Northwest Psychiatric Clinic

The Clinic, composed of a group of psychiatrists in Eau Claire, wishes the Society's support of a Symposium on Depression which it is planning for April of 1964, along the lines of its Symposium on Alcoholism held this April, except that it will not seek financing by a drug firm.

Doctor Frank and Mr. Crownhart reported conversations with representatives of the clinic and their wish to maintain the very highest standards of medical ethics. They will submit the program for approval by the Commission on Scientific Medicine. This year's program was approved for credit by the Academy of General Practice, and they are requesting approval of next year's program. They have received endorsement by the Wisconsin Psychiatric Association.

They would like endorsement of the Society to the extent of using its seal on the program, assistance with publicity, printing and mailing, and will submit papers for publication in the *Wisconsin Medical Journal* subject to approval of the Editorial Board. They would like some financial help as there will be no registration fee, but those attending will pay for dinner. Mr. Crownhart had indicated the possibility of providing a speaker, if the Council approves, through the CES Foundation.

Following discussion by the committee, Doctors Willson-Davis moved that the Planning Committee favor cooperating with the group so far as publicity is concerned, and that the question of subsidizing one speaker be forwarded to the Council to consider if money can be made available with the idea that this is a relatively new project of education that needs help until it can become self-sustaining by registration fees; provided that the Chairmen of the Commission on Scientific Medicine and the Division on Nervous and Mental Diseases be asked for their response to the motion. Motion carried, Doctor Kief voting "no."

Council Action: There was extensive discussion of the subject, revolving for the most part around the principle of the Society working with privately organized groups in this manner.

On motion of Doctors Dessloch-Nordby, carried, the matter was referred back with the suggestion that sponsorship of the proposed symposium be through the Division on Nervous and Mental Diseases of the Commission on State Departments, although held at Eau Claire.

b. Guide for Occupational Health Program for Hospital Employees

R. S. Baldwin, M.D., had been invited by Doctor Mason to review the guide and report to the Planning Committee. He felt that the subject was "covered in an excellent way and most of the intangible values are well preserved." He felt it was not offensive to medicine and thought that the Society could well give its approval so the guide could be made available to hospitals for use to the extent feasible.

Doctors Kief-Willson moved that the Planning Committee approve the General Guide for an Occupational Health Program for Hospital Employees and send it to the Council with that comment.

Council Action: On motion of Doctors Nordby-Van Hecke, carried, the Guide was approved by the Council, on recommendation of the Planning Committee.

c. Medicine and Religion

Mr. Arne Larson, assistant director, AMA Department of Medicine and Religion, discussed at some length the resources available from the AMA Department, and how various states are implementing the program. It is hoped that the program will be conducted at a county medical society level, with the state society providing the resources.

Doctor Kief noted that the Wisconsin Heart Association had announced a program in this area, and expressed concern that there might be too much duplication if various medical organizations as well as county medical societies were to have programs on medicine and religion.

After discussion the committee agreed that for the present, planning of appropriate coordination and development should be retained within the committee for further study and subsequent report to the Council, noting that a program on medicine and religion is planned for the 1964 Work Week of Health.

Doctors Davis-Willson moved that the Planning Committee report favorably to the Council, recommending that it endorse the program of the AMA Department of Medicine and Religion.

The committee suggested further that representatives of all county medical societies be expressly invited to observe the program during the Work Week of Health with the idea of using it as a format for meetings within their own areas. It was also agreed that the Planning Committee meet the evening this program is scheduled for evaluation of it.

Council Action: On motion of Doctors Dessloch-Blanchard, carried, the report and recommendation of the Planning Committee were approved.

d. Medic-Alert Foundation

The Secretary reported a recent communication from this Foundation, located in Turlock, California, enlisting cooperation in promotion of the "international program for identification and protection of hidden medical problems by use of a universal emblem."

The committee accepted the report and advised that the communication be filed.

Council Action: None.

e. Proposed Bylaw Amendments

(1) To provide for exemption of new members from the payment of dues during the year of election

This amendment was rejected by unanimous agreement.

Council Action: None.

(2) To provide for creation of a scientific fellowship

Council Action: On motion of Doctors Willson-Kief, carried, the Council forwarded to the House of Delegates a resolution to amend the Bylaws to create a Section on Scientific Fellows in Chapter VIII. (See proceedings of 1963 interim session.)

(3) County Society Constitution and Bylaws

The committee recommended a resolution for presentation to the House, amending Chapter XI, Section 1 of the Bylaws, by addition of the following sentence.

"Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply."

The committee also submitted, for Council action, a current revision of the model constitution and bylaws for county medical societies.

Council Action: On motion of Doctors Willson-Nordby, carried, the resolution to amend the bylaws was forwarded to the House (see proceedings of 1963 interim session) and the revised model constitution and bylaws wa adopted with an amendment by Doctors Nadeau-Mason, carried, that separate county society committees on public policy and on public health be recommended.

(4) To enlarge the Commission on Public Policy

Council Action: On motion of Doctors Nordby-Blanchard, carried, a resolution to amend Chapter VII, Section 4 of the Bylaws, was forwarded to the House as amended by Doctors Kief-Schulz, carried, that the Commission be authorized to elect its own executive committee of five members. (See proceedings of 1963 interim session.)

f. Area Planning for Hospitals

The committee reviewed a letter from the executive director of the Wisconsin Hospital Association citing its action that it "not endorse the introduction of legislation which would create Area Planning Councils in the State and make it mandatory that a governmental agency be responsible for the franchising of new or expanded hospital facilities. The Trustees do endorse voluntary efforts directed toward areawide planning and believe that these should be utilized to the fullest extent possible." In response to Mr. Crownhart's comment that a Society committee was considering similar action, Mr. Von Ehren wrote that he saw "no reason why the State Medical Society should not adopt a similar statement of policy, if it wishes to do so."

On motion of Doctors Willson-Kief, carried, the Planning Committee recommended to the Council that such a statement of policy be adopted.

Council Action: Recommendation approved on motion of Doctor Willson, variously seconded, and carried.

5. Report of Committee on Economic Medicine

Minutes of the committee's September 29 meeting were presented to the Council, with action as follows:

a. Dane County Study of Solo and Group Practice

Present for this portion of the committee meeting were representatives of the Dane County Medical Society, also Ovid Meyer, M.D., and Mr. John Rowland representing the AMA Commission on the Cost of Medical Care.

Fulfilling the commitment to report to the Dane County Advisory Committee and to the Council of the State Medical Society before releasing the report of the AMA Commission, Mr. Rowland reviewed that section of its report dealing with the pilot survey conducted in Madison "to determine the feasibility and possible methods of measuring differences, if any, in the cost of an illness to persons attended by physicians in two contrasting systems of medical care—solo or group practice."

Copies of the report were provided those present and discussed in some detail, but Doctor Meyer asked that there be no local release of the results until after the December meeting of the AMA in Portland, when it will be submitted to the House of Delegates along with the Commission's recommendations.

It was understood that until that time, the report should be considered as preliminary, but after the December meeting the Dane County Medical Society might wish to make a release to the news media which have indicated an interest in the survey.

Council Action: On motion of Doctors Willson-Ekblad, carried, this section of the committee report was received by the Council.

b. Pension Plan for Society Members

Doctor Nordby reminded the committee that there were some in the Council who felt this was giving an unusual opportunity to Seefurth-McGiveran that was not available to others, and the proposed plan was referred to the Committee on Economic Medicine for a recommendation.

In answer to an inquiry, Mr. Crownhart said that there had been no Society contact with or from another insurance company, but that Seefurth-McGiveran are the Society's brokers of record and doubtless had surveyed the field before recommending Bankers Life.

He also said that the AMA's program had just been announced, and this would give physicians another choice.

On motion of Doctors Blanchard-Schulz, carried, the committee recommended to the Council that the Society approve the Seefurth-McGiveran proposal for the purpose of making it available to the members, but not recommend it as an exclusive plan.

Council Action: On motion of Doctors Willson-Mason, carried, action on the recommendation was tabled until estimates are available as to the legal expense involved in developing this program.

c. Reasonable Choice of Physicians in Industry

Doctor Nadeau had expressed concern that industry in certain areas of the state is not providing a reasonable choice of physician as required by law.

Mr. Crownhart summarized the law which requires the provision of "reasonable choice," not the posting of the open panel, and reminded the commit-

tee that the project was under way of compiling new panels for distribution to all known employers in 1964.

The committee agreed that this would serve to remind employers, particularly since the panels are accompanied by a letter from the Industrial Commission citing the law and recommending posting of the panel.

Doctors Schulz-Blanchard moved that provisions of the Wisconsin open panel system be reemphasized and attempts made to bring it to the attention of employers.

Council Action: On motion of Doctors Ekblad-Wright, carried, this portion of the committee report was accepted.

It was suggested that the Commission on Public Policy consider the matter of expanding the specialty listings permitted in the open panel.

d. Arbitration Board

In a prior joint meeting of the Grievance Committee and the Committee on Economic Medicine to discuss the possible creation of an arbitration board, staff had been requested to study the experience in other states.

Mr. Crownhart reported that these contacts had produced information which was vague at best, and he felt that the Grievance Committee was performing this function.

Doctor Nordby agreed, from past experience as a member of that committee, with the limiting factor of getting attorneys interested in presenting problems to the Grievance Committee before an action is commenced.

With agreement of the Committee on Economic Medicine, he suggested that a statement of the function of the Grievance Committee be prepared, urging that its arbitration services be utilized where there is a prospective liability suit, or an aggrieved person thinks he has the basis for such a suit.

Council Action: On motion of Doctors Ekblad-Houghton, carried, this portion of the committee report was accepted, and a statement is to be submitted for approval and determination as to distribution.

e. Survey of Business Practices of Physicians

On motion of Doctors Blanchard-Schulz, carried, the committee approved, with minor revisions, the form to be used for the survey previously authorized by the Council.

Council Action: On motion of Doctors Willson-Nadeau, carried, this section of the committee report was received.

f. Physician-Pharmacist Information Program on Narcotics

Doctor Nordby reported for information of the Council that the committee planned to meet at a future time with the Wisconsin Pharmaceutical Association on this pending agenda item.

6. Report of Executive Committee—October 5 Meeting

a. Wisconsin Heart Association

Neither Charles Crumpton, M.D., nor W. B. Hildebrand, M.D., was able to be present at the Council meeting in support of a resolution submitted by the Board of Directors of the Wisconsin Heart Association for Council endorsement. The general purpose was to secure recognition of the function and accomplishments of the Association, and cooperation with and support of its activities by the Society and its individual members. The Executive Committee forwarded the matter without recommendation.

Council Action: On motion of Doctors Kief-Hill, carried, the resolution was not adopted as submitted, but returned to the Executive Committee for preparation of a statement reiterating general approval of the Wisconsin Heart Association and other voluntary organizations of which the Society stands in support.

b. Revenue Act of 1962

Council Action: On motion of Doctors Willson-Kief, carried, the Council accepted the Executive Committee recommendation of no action at this time on a statement originating from the American Institute of Architects relative to provisions of the Revenue Act of 1962 which it felt were inequitable.

The following actions were reported for information:

c. Uniform Medical Practice Act

This material has come before the Executive Committee and is being initiated at a national level. Further inquiries are being made and the subject will be reported to the Council in due course.

d. Complaint of Doctor Lokvam on the Special Service contract

On motion of Doctors Fox-Frank, the entire file on this subject is referred to the Councilor from that district for study and subsequent report.

Doctor Nadeau urged that the phrase "no fee schedule" not be used in reference to the Special Service contract.

e. Joint Commission on Pharmacy and Medicine

This Commission, organized by the American Medical Association and composed of representatives of both the medical and pharmaceutical profession, is now conducting inquiry by questionnaire. The matter has been held over by the Executive Committee for further study.

f. Conference on International Health

On motion of Doctors Frank-Nordby, no official representative will be appointed to attend this conference.

g. External Cardiac Massage

The Wisconsin Nurses Association has asked to meet with a committee of the State Medical Society to formulate a statement relative to certain problems in this area. After discussion it was determined that the matter be left to the discretion of the President, who named the Committee on Clinical Medicine.

h. Ethical Diet Institute

This organization, located near Mukwonago, inquired as to ethical and practical aspects of advertising its facilities. Further questions were asked, no response has been received, and the matter has been tabled by the Executive Committee.

i. Report of Commission on State Departments and Divisions

These were considered routine and on motion of Doctors Fox-Hill, were authorized for distribution to the House.

j. Miscellaneous

The following miscellaneous matters were handled:

A study is to be undertaken of further material to be circularized new members as is done by the Philippine Medical Association.

A conference relative to the possibility of an Association of the Professions is to be held.

Doctor Egan appointed G. B. Murphy, Jr., M.D., of La Crosse, as chairman of the Commission on Hospital Relations and Medical Education, and A. J. Richtsmeier, M.D., of Madison, to the vacancy caused by the departure from the state of R. S. Gearhart, M.D.

The committee submitted a slate of nominees for consideration of the Governor for appointment to the State Board of Nursing.

The staff will assist with a sports tournament should there be sufficient interest.

7. Special Report of Executive Committee on Out-of-State Meetings

On motion of Doctors Dessloch-Nordby, carried, the Council transmitted to the House of Delegates the report prepared by Doctor Hill on instruction of the Executive Committee. (See proceedings of 1963 interim session.)

Doctors Willson-Van Hecke offered an amendment that a fiscal note be incorporated on the variation in expense between holding meetings out-of-state or in Society headquarters, information not immediately available. The amendment was defeated.

The request of Doctor Bernhart that the amount of reimbursement allowed AMA delegates be reconsidered was referred to the Finance Committee on motion of Doctors Willson-Nordby, carried.

8. Report of Executive Committee of the Foundation

The Secretary reported the following actions:

a. Authorization to change the fiscal year of the Foundation to coincide with that of the State Medical Society.

b. Recognition of the fact that the Foundation is growing and needs staff implementation in the near future. The Finance Committee is requested to consider this.

On motion of Doctors Ekblad-Nordby, carried, the report was accepted.

9. Recommendations of Commission on Public Relations and Communications

a. Recognition of Miss Alice Budny, Milwaukee, President of the American Association of Medical Assistants.

The Council unanimously approved a message of congratulations to Miss Budny upon completion of her term as president of the AAMA.

b. Television Station Break Slides

The Commission recommended a $500 appropriation in the 1964 budget to furnish slides containing health messages to television stations in the state for use during station breaks, in time given to public service.

On motion of Doctors Nordby-Kief, carried, the recommendation was approved.

c. Regional Rural Health Conferences

A member of the Commission had recommended that the Society consider holding a series of regional rural health conferences, and at the same time the Wisconsin Health Council, Inc., an organization of which the State Medical Society is a charter member, was investigating the possibility of holding a similar series. The Commission recommended that the Society encourage the Wisconsin Health Council to hold the conferences.

On motion of Doctors Kief-Schulz, carried, the Council expressed its support of the Wisconsin Health Council in a series of regional rural health conferences.

10. Kerr-Mills

Two resolutions were introduced by the Commission on Medical Care Plans:

a. Commending the bipartisan support of the Wisconsin Legislature and Governor in passage of implementing legislation.

On motion of Doctors Dessloch-Nadeau, carried, this resolution was transmitted to the House of Delegates. (See proceedings of 1963 interim session.)

b. Authorizing the addition to the directing body of Wisconsin Health Service of representatives of allied and ancillary professions.

On motion of Doctors Dessloch-Nordby, carried, this resolution was tranmitted to the House of Delegates. (See proceedings of 1963 interim session.)

11. Report by Legal Counsel

a. Status of Podiatry Suit

Mr. Murphy reported that judgment had been entered which was favorable in so far as it held that podiatrists are not doctors of medicine even for insurance purposes, and that WPS has the legal right in drafting contracts to limit reimbursement to licensed physicians and surgeons or anyone else specifically designated. It was also found by the court that the Commissioner of Insurance may find contracts to be ambiguous, and any such ruling is itself subject to amendment or appeal. He said that Mr. Kluwin and his office were awaiting opportunity to meet with the Commissioner and his staff on an interpretation of the latter point.

b. The matter of res ipsa loquitur

Earlier this year the Supreme Court limitedly adopted the rule of res ipsa loquitur in a case involving a Wisconsin physician. In July, the Council had approved a recommendation that an article explaining this doctrine be published in the *Wisconsin Medical Journal.*

Mr. Murphy reported that the case was scheduled for retrial, and the Council agreed that it would be untimely to publish anything on the matter until it is completed.

12. Council Award and Presidential Citation

Qualifications for these two awards were reviewed with the Council, and members were reminded to submit any nominees they have in mind to be considered for 1964.

13. New Business

a. Maryland resolution to AMA House of Delegates

This resolution, requesting a review of AMA policy regarding the use of Federal Funds for medical services, staffing and construction, had been forwarded to the Wisconsin delegates by the Executive Committee of the Council for comment. Doctor Galasinski reviewed past discussions of the subject and asked if the Council had any advice to offer the delegates. Following custom, the Council took no action to instruct them.

b. Division on Maternal and Child Welfare

Doctor Fox read a communication from the chairman of this division relative to continuation of the pilot course for obstetrical nurses, and proposing certain arrangements for an educational program for osteopathic physicians and surgeons on maternal mortality.

The Council felt that additional information was needed regarding these proposals, which were referred to the Scientific Committee of the Council on motion of Doctors Kief-Houghton, carried.

14. Adjournment

The Council adjourned at 11:30 p.m.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman

THE COUNCIL—State Medical Society of Wisconsin

MARCH 14, 1964: Seated around the Council table, left to right, are: N. A. Hill, M.D., Madison, past president; D. M. Willson, M.D., Milwaukee, councilor–12th district; W. D. James, M.D., Oconomowoc, councilor–1st; C. W. Stoops; M.D., Madison, councilor–3rd; P. B. Blanchard, M.D., Cedarburg, councilor–5th; S. L. Chojnacki, M.D., Milwaukee, councilor–12th; E. J. Nordby, M.D., Madison, councilor–3rd; M. D. Davis, M.D., Milton, councilor–3rd; Marvin Wright, M.D., Rhinelander, councilor–13th; J. M. Bell, M.D., Marinette, councilor–8th, and vice-chairman; J. C. Fox, M.D. La Crosse, councilor–7th, and chairman; Mr. C. H. Crownhart (standing), Madison, secretary; W. J. Egan, M.D., Milwaukee, president; L. J. Van Hecke, M.D., Milwaukee, councilor–12th; E. M. Dessloch, M.D., Prairie du Chien, councilor–4th; R. W. Mason, M.D., Marshfield, councilor–9th; H. J. Kief, M.D., Fond du Lac, councilor–6th; V. E. Ekblad, M.D., Superior, councilor–11th; W. J. Houghton, M.D., Milwaukee, councilor–12th; G. J. Schulz, M.D., Union Grove, councilor–2nd; and S. W. Hollenbeck, M.D., Milwaukee, councilor–12th. Others who were not present for the picture are: R. C. Frank, M.D., Eau Claire, councilor–10th; George Nadeau, M.D., Green Bay, councilor–6th; and R. E. Callan, M.D., Milwaukee, speaker of the House of Delegates.

Staff members and consultants shown in the background, upper left hand corner, are, left to right: (standing) R. T. Ragatz, Madison, assistant secretary; H. L. Toser, Madison, insurance director; D. C. Reynolds, Madison, field services director; (seated) A. A. Quisling, M.D., Madison, delegate to the American Medical Association; R. H. Hansen, Madison, public information director; and W. P. Curran, M.D., Antigo, president-elect. Seated in the background, upper right hand corner, are: Joan Pyre, Madison, committee secretary; Mrs. Jean Anderson, Madison, personnel director; J. B. White, Madison, accounting consultant; C. A. Tiffany, Chicago, Ill., actuarial consultant; and R. B. Murphy, Madison, general counsel.

EXHIBITS OF MEDICAL HISTORY

PRESERVATION OF MEDICAL RECORDS

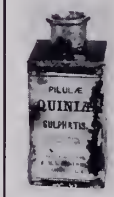
MEDICAL MEMORABILIA

COINS AND MEDALLIONS

MEDICINE IN ART

OLD TIME DRUG STORE

HOBBIES FOR HEALTH



HISTORICAL ARTIFACTS

SPECIALIZED STAMPS

the Section on Medical History

CREATED IN 1953

"Dedicated to the Preservation of Our Medical Heritage"

It has been said, and truthfully:

"History is not only that which is hundreds of years old. History is today's events. They should be recorded for the time when they can be evaluated in the light of experience and impartiality."

INTRODUCTION

ALTHOUGH THE SECTION on Medical History was not created until 1953, its conception began in 1908 when W. E. Ground, M. D., of Superior, who was then president of the State Medical Society, encouraged and stimulated membership interest in preservation of medical history. This interest has fluctuated through the years as officers changed, but the spark has always been there. Such men as Hoyt E. Dearholt, E. J. Barrett, William Snow Miller, Curtis A. Evans, and F. J. Antoine will be remembered as supporters of this movement. Present officers of the Section are: W. D. Stovall, M.D., president; E. M. Dessloch, M.D., vice-chairman; Mrs. Ottilia Orth, vice-chairman; C. H. Crownhart, secretary–treasurer; and E. J. Nordby, M.D., membership chairman. To finance the historical collection there is a membership dues of $5.00 per year. Section members total about 100. A renewed effort to increase this membership for expansion of the Section activities has just begun with an invitation to each member of the State Medical Society to join the Section. Physicians and others are also urged to contribute artifacts and items of historical significance to this collection. This page will be presented each month in the *Wisconsin Medical Journal* as a means of expressing thanks and recognition to those who contribute.

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

HISTORICAL MARKERS

MANUSCRIPTS AND PAPERS

MEDICAL MUSEUM

HIGHLIGHTS OF SECOND ANNUAL

WISCONSIN WORK WEEK OF HEALTH

THE MEDICAL ASPECTS of alcoholism in industry was the subject of a talk by Sidney S. Greenberg, M.D. (left), while Arnold S. Zentner, M.D. (right) spoke on the profile of the alcoholic at the Tuesday session featuring Alcoholism and Industry. Both physicians are on the staff of the Consultation Center for Alcoholism, New York University Medical Center, New York.

"Both industry and labor are beginning to accept these employees as sick people," Doctor Greenberg stated. "In years past industry would merely punish the alcoholic by firing him. No company can afford such economic waste," he said.

Industry is in a key position to help the alcoholic according to Doctor Zentner's remarks. Although few "threats" help in the rehabilitation of the alcoholic, "one of the most effective is the possible loss of his job," he stated.

The Wisconsin Work Week of Health was initiated in 1963 to provide a forum where a great many matters of interest to the medical profession and the general public could be examined.

By combining the diverse topics into one week-long series of conferences, the attention of the public is focused on them and on the factual and philosophical information presented.

The Wisconsin Work Week of Health also offers an opportunity for an informal exchange of information by the participants. It enables those with similar interests to meet each other and express their viewpoints.

While the topics change from year to year, the overall concept remains the same—to take stock of our health personnel, our facilities, areas which need attention, people who have special problems—and most important, to examine the trends and philosophies which will determine Wisconsin's health in the future.

■ SEVENTEEN agencies and organizations and 50 experts on health subjects joined the State Medical Society of Wisconsin to present the second annual Wisconsin Work Week of Health February 24–29 in Madison at the Society headquarters.

The conferences, which dealt with a different phase of health each day, were open to the public, and there was no registration fee although advance registrations were desired. The six-day program attracted an audience of 1,276 persons who were given free box lunches at noon as well as coffee and cookies during mid-morning and mid-afternoon breaks.

During breaks in the program, guests were escorted on tours through the Medical Society building in which there are many exhibits and items of medical and historical significance including several pieces of art which are a part of the CES Foundation's "Medicine in Art" collection.

The tremendous scope of the entire program is shown by the diversity of subjects covered: emergency care by nonmedical personnel, alcoholism and industry, mental retardation, medicine and religion, medical-legal-economic problems, voluntary health agencies, and international medical public relations.

The conferences resulted in the following conclusions:

1. The greatest cause of mental retardation is prematurity; and if all expectant mothers would seek prenatal care, many cases could be prevented.

2. Testing in the early weeks of life can prevent certain types of retardation, and pilot programs are being conducted to determine the best manner of testing.

3. The physician's role in retardation is to identify the retarded child and appraise his potential, orient the parents and community to the problem, and help the family find the resources available to help in the education of the child.

THE PRESIDENTS ROOM in the State Medical Society building accommodated a maximum group of 220 persons during the Work Week of Health. Attendance exceeded this figure on three days, necessitating the use of the dining room and Council Room where the speeches were heard through the intercom system.

A REFORMED DRINKER, who is a member of Alcoholics Anonymous, and introduced as Larry M————, told of his personal experiences with alcoholism at the Tuesday session. He is shown above at the left talking with three other speakers on the program: Joseph R. Matejicka, lieutenant of police, Milwaukee Police Department, Milwaukee; Robert A. Moore, M.D., assistant professor of psychiatry, The University of Michigan, Ann Arbor; and James S. Ray, administrator, Milwaukee Council on Alcoholism, Inc., Milwaukee. Mr. Matejicka explained how the courts can help in rehabilitation while Doctor Moore discussed the legal rights and problems of the alcoholic.

Mr. Ray spoke on utilizing community resources. His frank assessment of the alcoholic problem in Wisconsin revealed that "industry is not yet really alarmed about alcoholism. We're where tuberculosis was 40 years ago." He cautioned the employers against sending an alcoholic to any clergyman or doctor since many are unsympathetic to the problem. Some welfare case workers often find "amputees and children more appealing psychologically," he said. "Industry cannot expect others to do the job. You must build the resources to aid alcoholics," Mr. Ray said. A lively session of questions and answers produced much constructive information.

* * *

SPEAKERS ON THE MENTAL RETARDATION program included those shown below, left to right: Harry A. Waisman, M.D., professor of pediatrics, University Hospitals, Madison; John W. Melcher, director, Bureau for Handicapped Children, State Department of Public Instruction; Harvey A. Stevens, superintendent, Central Wisconsin Colony and Training School; and James F. McDonald, president, The Wisconsin Council for Retarded Children. Mr. McDonald moderated the program while the other three spoke on the implications for Wisconsin of the Report of the President's Panel on Mental Retardation.

Doctor Waisman said "the greatest cause of mental retardation is prematurity. If the mother gets adequate prenatal care, many of the complications which cause retardation could be prevented." He stressed observation and tests of the new baby in the first weeks of life as another important preventive measure. Citing his own research in a specific cause of retardation, phenylketonuria, he pointed out that if it is discovered in the first week of life, these children may attain an I.Q. of 85—110. After one year the expectation is an I.Q. of 60. Three or more years and it is 20. However, he stated that in a pilot program of giving the simple testing materials to mothers when they leave the hospital, to be returned later to his laboratory, the response has been about 50 per cent.

According to Mr. Melcher, Wisconsin ranks well ahead of many other states in the educational opportunities offered retarded children. "In the United States 2 of 10 mentally retarded children who would qualify for special education are getting it," he said. In Wisconsin the figure is 6.5 of 10. However, he cited the need for increasing this number and for training more teachers for special education. "If we don't have the teacher who can do the job, the rest doesn't matter," he said.

4. Wisconsin ranks well ahead of most states in educational opportunities for retarded children, but 35 of 100 still do not receive special education in the state.

5. Facilities for residential care of retarded children are overcrowded; although 1,200 new beds are being planned, an additional 1,000 will be needed by 1970.

6. Industrial concerns which have programs to aid alcoholics achieve a high rate of rehabilitation and realize economic gains by cutting absenteeism, accidents, and loss of materials.

7. There is presently a disagreement on the nature of alcoholism with physicians regarding it as a medical problem and the law treating it as a criminal problem. Courts, in realizing this difference, have a difficult problem in dealing with offenders.

8. Physicians and clergymen presently work together in many areas of caring for the patient, but more effort is needed in developing a "team" approach.

9. Ambulance speed is seldom a factor in aiding the patient, and

MODERATOR OF THE alcoholism program was Dr. C. A. Wunsch of Green Bay (left). Henry A. Mielcarek (right), manager of the Personnel Service Section of the Allis-Chalmers Manufacturing Company, Milwaukee, spoke on the problems of alcoholism in industry. He stated that "there are over five million alcoholics in the country, and more than half are employed in business and industry. The cost in absenteeism, accidents, and loss of materials is considerable, however the alcoholic is often a man in a key position. It is more economical to aid in his rehabilitation than to replace him.

Outlining the program that began some 20 years ago at Allis-Chalmers, a pioneer in the field, Mr. Mielcarek stressed that "the rate of recovery of these cases is dependent on early discovery and the desire for recovery within the individual whose drinking hampers his work." The program uses community facilities, including members of the clergy, Alcoholics Anonymous, and governmental services. In addition the company provides legal counsel, recreational facilities, and even loans for the problem drinker working his way back to a "dry" condition.

METHODS OF WORKING TOGETHER in religion and psychiatry were discussed by speakers, left to right above, Leigh M. Roberts, M.D., University Hospitals, Madison; Smiley Blanton, M.D., director of the American Foundation of Religion and Psychiatry, New York; and the Rev. John R. Thomas, chaplain supervisor, Mendota State Hospital, Madison. All three were featured speakers at the Thursday session on Medicine and Religion.

Three areas where medicine and religion presently work together, and the hope that this could be broadened to a "team" approach to illness, were outlined at the conference. These three areas are: instilling the faith and will to live which can be a significant factor in the patient's recovery, the field of mental health when the clergyman has been trained to detect early indications of trouble, and interpreting to the patient and his family in cases of serious or terminal illness.

OTHER CONFERENCE SPEAKERS during the Medicine and Religion session are left to right above, Karl H. York, administrator, St. Luke's Memorial Hospital, Racine; Rabbi Manfred E. Swarsensky, Temple Beth El, Madison; and Father Lawrence J. Kieffer, St. Thomas congregation, Potosi.

Indicating that there is a much broader base for cooperation, Rabbi Swarsensky said, "There is great hope in building in our society a partnership of those who are concerned with caring for people. However, one problem that must be overcome is that some physicians as men of science regard religion as unscientific."

"At the hospital scene we must develop the team concept and define the role of each member of the team," said Mr. York. "True consultation between the physician and clergyman is a rarity in the hospital today."

The day's program ended with a film, "The One Who Heals"—Physicians confront medical problems involving faith.

care received at the accident scene is more important to the patient's welfare.

10. At least one member of each family unit should be trained in first aid.

11. Redesign of automobiles, as the result of research being conducted by Cornell University, is reducing the chance of injury or death in an accident.

12. American medicine has chosen a unique method of reaffirming the belief that people, working with people, is still the most effective way of building positive international relations—and that is through Project HOPE, whose purpose is to bring the skills and techniques developed by the American professions to the people of other nations in the knowledge that self-help is the best help.

13. Every physician in this country has a vested interest in the tremendously important research programs being supported by the voluntary health agencies, but it behooves every physician to seriously question any program of fund raising, such as the United Health Foundation, Inc., which would seek to force these agencies into programs which would dilute or destroy the effectiveness of the programs now being carried out.

14. Dedicated volunteer workers for local health organizations need the aid of their local physicians desperately and the physician should provide guidance and advice in the medical matters with which these agencies are so intimately involved.

TAXES AS THEY AFFECT professional practice were discussed by speakers, James O. Ash, C.P.A., La Crosse, left below; and Warren H. Stolper, attorney, Madison, right below. In the center is Philip S. Habermann, executive director, State Bar of Wisconsin, Madison, who was moderator of the Medical-Legal-Economic Conference on Friday.

RETARDATION FROM THE VIEWPOINT OF THE PHYSICIAN was explained by H. Kent Tenney, M.D., chairman, State Mental Health Advisory Committee, Madison, who is shown below at the left discussing the program events with Matthew D. Davis, M.D. and his wife, Madison, who were also speakers at the Mental Retardation Conference on Wednesday.

COMMENTS

THE WISCONSIN Work Week of Health is sponsored by the State Medical Society of Wisconsin and represents what a well organized society can accomplish in the field of special health problems facing citizens of the state. The dedicated staff of the State Medical Society has obviously put in a tremendous amount of time and effort to make this project a success. The week's activities mark another important step by the State Medical Society in functioning as a public service agency for the people of Wisconsin and a personal service organization for the physician. The Society deserves much credit for the program and its year around cooperation with state and voluntary health agencies.—*The Daily Telegram*, Eau Claire, Feb. 28, 1964.

* * *

I WISH TO thank you for the opportunity of attending the workshop on "Alcoholism and Industry" . . . thought it was very informative from a layman's view. I personally knew seven labor members at this particular session and was very pleased to hear their fine comments.—*Marvin E. Brickson*, President, Madison Federation of Labor AFL-CIO.

* * *

WAS VERY much impressed with the programs and the speakers. It was time well spent.—*Frederick S. Voegeli*, Voegeli Funeral Home, Monticello.

* * *

ALL OF US from Beloit who attended the meeting at the Medical Center on Monday agree that it was a day well spent. The speakers were well planned and most informative. Your building is beautiful and your gracious hospitality delightful. We urged some of our clergy to attend the Thursday meeting. We recommended the entire program.—*Mrs. Eleanor J. Waterman*, Executive Secretary, The American Red Cross, Beloit Chapter.

THE SPEEDING AMBULANCE, with siren sounding and red light flashing, may be a thing of the past, according to Capt. John Schoenick, director of the Wisconsin State Patrol Academy at Camp McCoy. "We have overwhelming evidence that speed is seldom necessary for the welfare of the accident victim," he told 245 emergency care personnel at the opening session, Monday, of the Wisconsin Work Week of Health. "The care received at the scene of the accident is mare impartant," he added. "Everyone concerned would agree that there is no need for ambulances speeding," Capt. Schoenick stated, but added that it would require education, regulation, and perhaps a change in the laws to stop it.

Those attending the Conference on Emergency Care by Non-Medical Personnel also heard presentations by Robert M. Senty, M.D., Sheboygan, who discussed artificial respiration and circulation; N. Peter Braun, M.D., Sheboygan, who discussed care of localized trauma; and William Kiekhofer, M.D., Madison, who discussed the subject, emergency obstetrics. Discussion leaders of workshop sessions were James L. Weygandt, M.D., Sheboygan Falls; Eugene E. Eckstam, M.D., Monroe; and Walter F. Smejkal, M.D., Manitowoc.

Legal responsibilities of those who render emergency care were discussed by Stephen E. Gavin, manager, Wisconsin Chapter of The Associated General Contractors of America, Inc., Madison. Mr. Gavin emphasized that a person rendering first aid in an accident should "not hold back for fear of being sued. This is a dramatic issue and not a practical problem."

Robert W. Gillette, executive director, Wisconsin Council of Safety, outlined the work of the Council. Problems in automotive safety design were outlined by Richard C. Braisted, head of the field branch, Automotive Crash Injury Research, Cornell Aeronautical Laboratory, Inc., Buffalo, New York. Mr. Braisted pointed out that research by Cornell University, aimed at presenting a safer "package" for the auto passenger, has contributed to safety changes in auto design—specifically, auto seat belts, improved door latches, and safer instrument panels. Current research is being directed toward the value of laminated glass and improvement of the steering column. The Cornell group conducted a study in Wisconsin from July 1, 1961, to June 30, 1963, as part of its program.

As moderator for the conference, Richard B. Windsor, M.D., chairman of the State Medical Society's Division on Safe Transportation of the Commission on State Departments, stated that "at least one member of every family unit should be trained in first aid." The Division planned the program.

R. B. Windsor, M.D.

R. C. Braisted

Jahn Schoenick

R. W. Gillette

DISCUSSING PARTNERSHIPS and legal requirements of personal corporations at the Friday session of the Medical-Legal-Economic Conference are, left to right above, Robert B. Throckmorton, general counsel of the American Medical Association, Chicago; George T. Burrill, C.P.A., Madison; W. J. Egan, M.D., president, State Medical Society of Wisconsin, Milwaukee; and Frederic Sammond, attorney, Milwaukee.

SPEAKERS AT THE FIFTH ANNUAL Conference of County Medical Society Officers, held on Saturday during the Work Week of Health, were, left to right below: Morris Fishbein, M.D., editor, MEDICAL WORLD NEWS, Chicago; Herman L. Toser, insurance director of the State Medical Society of Wisconsin, Madison; J. Scott Butterworth, M.D., past president, American Heart Association, New York; and Ralph C. Frank, M.D., past president, Wisconsin Division of the American Cancer Society, Eau Claire. The speakers discussed the roles of voluntary agencies and united funds in health matters. They agreed that each served a role and encouraged physician support at the local level.

* * *

THE ROLE OF THE C.P.A. IN THE professional practitioners business was discussed at the Medical-Legal-Economic Conference Friday by John W. Ullrich, C.P.A., Wausau (left below). Herbert Terwilliger, attorney, Wausau (second from left), and E. J. Nordby, M.D., Madsion (right), teamed up for a discussion of charges for professional services in litigation—fee schedules between professions. Where do the professions go from here was the subject of a talk by Hugh W. Brenneman, executive director, Michigan State Medical Society, East Lansing (second from right).

COMMENTS

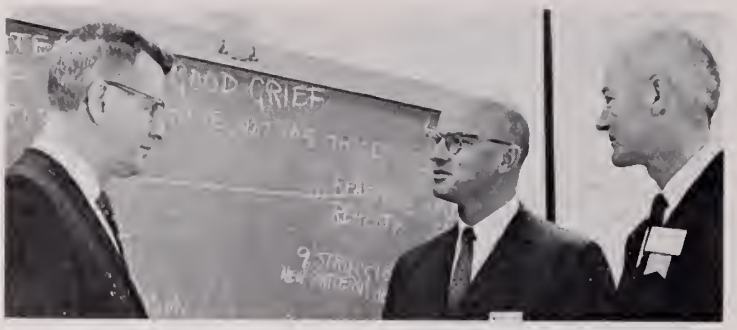
IT WAS MY privilege to attend . . . I enjoyed it very much and wish to express my appreciation for the splendid program and the good meals. This type of communication is very good for all concerned.—*Rev. Layton N. Jackson,* Presbyterian Hospital Chaplain, Montello.

* * *

I AM VERY impressed with the program that the State Medical Society has set up for this year's Health Week . . . I regard the subject matter both timely and important . . . I congratulate the State Medical Society for their planning in connection with this Wisconsin Work Week of Health.—*Wilbur J. Schmidt,* Director, State Department of Public Welfare.

* * *

THE MEDICAL Society is to be commended on the excellence of its Second Annual Work Week of Health. The selected areas of concentration met the needs of today; the speakers, those I heard . . . were men of integrity, profound knowledge, and experience. But no program, regardless of the interest of its topics or the caliber of its speakers, will have much impact on those who attend, unless it is well organized. The mechanics of having things run smoothly, and on time, require careful planning. Your program reflected that thoughtful approach, from the functional programs (I especially appreciated having the calendar on the front cover and the valuable insert as to the location of the building on the back cover), to the box lunches and the coffee breaks without charge. Lastly a word of thanks to the many guides, hostesses, registrars, and other personnel, all of whom were gracious and helpful to us at all times.—*Sister Margaret Mary, O.S.F.,* Coordinator of Health Services, Alverno College, Milwaukee.



DURING THE MEDICINE AND RELIGION session on Thursday, the moderator, Arne E. Larson (right above), assistant director, Department of Medicine and Religion, American Medical Association, Chicago, stressed a need for doctors and clergymen to meet and "discuss their common relationship in the care of the whole man." He said that programs on religion and health have been inaugurated in over 40 states. Other featured speakers were the Rev. Granger E. Westberg (left), associate professor of religion and health, University of Chicago; and Donn G. Mosser, M.D. (center), director of radiation therapy, University of Minnesota Hospitals, Minneapolis. Doctor Mosser, who treats 40 to 60 cancer patients each day, dealt particularly with the patient who has a serious or terminal illness. "I think we have to convey to the patient the desire to live even if it will be a limited type of life," he said. "A patient who has given up goes visably down hill almost immediately. If we have to develop a philosophy of life and death after the patient goes into the hospital, the time is short," he concluded. The Reverend Westberg discussed what the clergy expects of the medical care team.

THE WISCONSIN WORK WEEK OF HEALTH was dramatically concluded with a stirring talk by William B. Walsh, M.D. (left below), guiding spirit and medical director of the 15,000-ton hospital ship, S. S. HOPE. Speaking before the fifth annual conference of county medical society officers on Saturday, Doctor Walsh briefly outlined the short but glowing history of the People to People Health Foundation, Inc., founders of Project HOPE. HOPE began in the fall of 1958 when President Eisenhower asked Doctor Walsh to initiate a project aimed at international good will and understanding through personal contacts.

The 230-bed hospital ship is staffed with volunteer American medical personnel who work aboard the ship or join the inland medical teams to extend the hand of HOPE beyond the mere shoreline. More than 500 American physicians, dentists, nurses, and auxiliary personnel have served aboard HOPE. Five Wisconsinites are among her honor roll call, Doctor Walsh pointed out. Three physicians, Dr. J. S. Vedder, Marshfield, and Dr. William B. Gallagher, La Crosse, served. Dr. John Peden, Owen, is now serving in Ecuador. One registered nurse, Miss Elizabeth Ahern, Fond du Lac, signed on for a second tour of duty. Robert A. Peterson, Hollandale, has served as a public information official.

Over 45,000 patients have been treated, 4,000 major operations done, and almost a half a million benefited through immunization, examination, and other HOPE services. Said Doctor Walsh, "Project HOPE has a simple basic philosophy. It is built upon the belief that the single most important social and economic unit is still the human being. The health of this unit is the foundation upon which all social and economic progress must rest." The S. S. HOPE has served in Indonesia, South Viet Nam, Peru, and is currently in Ecuador. Plans are being made for the ship to train medical personnel in Africa. In conclusion Doctor Walsh said, "The purpose of Project HOPE has never faltered: To bring the skills and techniques developed by the American professions to the people of other nations in the knowledge that self-help is the best help."

Visiting with Doctor Walsh at the dinner given in his honor Friday night, are James C. Fox, M.D. (center), chairman, Council of the State Medical Society of Wisconsin, La Crosse, and W. J. Egan, M.D. (right), president, State Medical Society of Wisconsin, Milwaukee. Doctor Fox was moderator for the Saturday session. Doctor Egan was host for the entire week.

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Wisconsin Society of Certified Public Accountants
State of Wisconsin Mental Health Advisory Committee
Woman's Auxiliary to the State Medical Society of Wisconsin
Wisconsin Council of Safety, Inc.

ATTENDANCE

Mon., Feb. 24, Emergency Care by Non-medical Personnel	263
Tues., Feb. 25, Alcoholism and Industry	135
Wed., Feb. 26, Mental Retardation	276
Thurs., Feb. 27, Medicine and Religion	404
Fri., Feb. 28, Medical-Legal-Economic Conference	132
Sat., Feb. 29, Fifth Annual Conference of County Medical Society Officers	66
Total	1,276

the wisconsin medical journal

VOLUME 63/NUMBER 5 MAY 1964

Clinical Use of the Antidepressant Drugs

By LEIGH M. ROBERTS, M. D. and MILTON H. MILLER, M. D.
Madison, Wisconsin

■ THE COMPLEX clinical syndrome of mental depression has always represented one of man's most heavy afflictions. From the perspective of the stricken patient, no other illness is as discouraging, as courage-robbing, and seemingly endless. And over the years, few illnesses have confronted the medical clinician with a greater sense of his own therapeutic inadequacy and inability to be of help. Thus, the curative developments which result in a better and more effective management of this disturbance are heartily welcomed by patient and clinician alike.

One such gain was the development of the convulsive therapies in the mid-thirties. A second advance has been achieved during the last eight years with the development of effective antidepressant medications.

This report will review the use of certain of these antidepressant drugs presently available for use in clinical practice. Because of their relative newness and because of the general complexity of the syndrome of depression, an understandable lag exists in their application and not all physicians are familiar with their potential significance in medical practice.

Stated simply, the new antidepressant medications, properly administered, and given time to become effective, work! In the authors' experience, more than one-half of those depressed patients who might have been given electroshock therapy only six years ago can now be treated without such therapy. Even in those instances in which convulsive therapy is needed, the combination of antidepressant medication plus convulsive treatments has resulted in a decrease in the number of convulsive treatments.

Nevertheless, although depression is a commonly encountered symptom, diagnosis remains at times, very difficult. And, although effective, the new drugs require particular familiarity in their mode and time of action, their side effects, indications, and contraindications.

Recognition of Depression. In all likelihood, failure to recognize either the presence or severity of depression is the most common error involving emotional illness.[1, 2] No physician, including psychiatrists with many years of experience, practices his profession long without failing in certain cases to adequately estimate the magnitude of despair in his patient.

There are many reasons for this tendency to underestimate depression. Many patients are embarrassed about emotional illness and tend to cover up frankly psychiatric symptoms. The underlying illness is overlooked in other patients because the physician devotes his therapeutic attention to a somatic complaint with which the patient presented himself but which complaint was really a "ticket of admission" to enable the patient to see the doctor.

From the Department of Psychiatry, University of Wisconsin Medical School.

In other instances, depressive symptoms are more diffuse and generalized, and resemble, or can be confused with somatic, often systemic illnesses. In these instances, weight loss associated with loss of appetite or generalized symptoms of anxiety such as increased blood pressure, sweating, dyspnea, agitation, headache and visual difficulties may predominate. Sleep disturbance, so common in depression, may be attributed to various pains. The patient's profound concern may be falsely attributed to "worry about high blood pressure," or the like.

Diagnosis will rest upon the physician's ability to appraise the total picture presented by his patient and a sustained awareness of the frequency with which depression occurs. The physician needs to be aware that severe depression is especially likely to occur in mature adults, beyond 35 or 40 years of age and extending to patients of 80 years or more. The authors have frequently treated classically depressed patients in the 70's or even 80's whose illnesses had been confused with senile brain syndromes. Unhappily, many of the more than 25,000 suicides each year represent a misdiagnosis. We psychiatrists, along with other medical practitioners, make these tragic misjudgments.

The family physician will need to make the decision of whether to attempt to treat the patient in his practice, whether to refer the patient to a specialist for therapy, or perhaps whether to refer the patient to a specialist for consultation and advice about therapy which the physician might himself carry out. Where the risk of suicide seems great, or where the patient's symptoms are unusually severe or prolonged, the referral to a specialist should be prompt.

Use of Antidepressant Drugs. The drug market has been flooded in recent years by a large number of psychopharmacologic agents which have therapeutic effects on the symptoms of depressive disorders.[3] Their number is so great that it is simply not possible for any physician to know well the therapeutic effectiveness, dosage ranges, toxic effects, and limitations of each of these agents with any exactness. Instead, it is desirable for the physician to achieve a more intimate knowledge of one or two medications in a group rather than to aim for a vague familiarity with all of the available agents. In this respect, we feel that physicians should endeavor to know one or two antidepressant drugs well!

Many patients referred to the psychiatrist with depressive symptoms have already been placed on treatment with antidepressant drugs by the family physician. The referral often occurs when the drug used is viewed as failing to relieve the symptomatology due to the ineffectiveness of that compound with the particular patient. In a number of such referrals, patients have been receiving an inadequate drug dosage for an inadequate period of time. The antidepressant medications may require a relatively long time before their effect is felt. A three or four week trial is necessary before one can know whether a given medication will work. And in the authors' experience, some of the most successful therapeutic efforts were not manifest before four weeks had elapsed!

When the physician is less than fully familiar with a particular drug he tends to be conservative in the dosage he prescribes. Many patients also attempt to get along on a minimum dosage and may ingest less than that prescribed by omitting occasional doses when they feel a little better. All these factors tend to reduce the dosage of these drugs below an optimum therapeutic level which must be maintained if they are to prove effective. An adequate dosage level must be prescribed and regularly taken if it is to prove helpful in relieving depression.

Antidepressant medications are not interchangeable with "tranquilizers." In fact, tranquilizers rarely alleviate severe depression and several of them are well known as offenders in precipitating the onset of depression. Thus, such medications as the following are rarely of much use as primary agents in lifting severe depression: chlorpromazine (Thorazine), promazine (Compazine), trifluoperazine (Stelazine), meprobamate (Equanil), phenobarbital and hydroxyzine (Vistaril). They may, however, be combined with an antidepressant drug to relieve the agitation some depressed persons experience.

Time passes with seeming interminable slowness for depressed patients and if ever a good doctor-patient relationship is required, it is with such patients. Faith in the doctor and in his medicine which will not start to work for a few weeks is vital. Medications which are slow to begin giving relief

accentuate a need for the art of medicine and the art of giving medications.

The physician needs to know well the nature of the side effects and possible toxic effects from the drug which he is using. The patient who is troubled by annoying symptoms needs prompt reassurance regarding those inconveniences with which he must live in taking the medication and equally prompt symptomatic management of those side effects which have countermeasures available for their alleviation or cessation. Where side effects persist despite all management efforts to diminish them, the relative merit of the treatment must then be weighed against the distress of the symptoms induced by the side effects in the patient. Depressed patients are often suspicious of medicines and are especially likely to be dissuaded from taking their medicine.

Laboratory studies such as blood cell count, urinalysis, and liver function studies are helpful baselines prior to initiating therapy with antidepressant drugs. It is difficult to evaluate a subsequent borderline or abnormal laboratory value in these areas without such a baseline study preceding use of the drug. Repeat laboratory studies usually are needed only when there is a clinical indication of abnormality in the patient. Any suspicion of a toxic drug effect should be promptly investigated when a patient has been placed on antidepressant drug therapy.

A difficult question is posed for the clinician related to the optimum length of drug therapy when one is dealing with an illness of such uncertain course and duration as is the case with depression. The best answer is to maintain it as long as it is necessary to maintain symptomatic control of the depressive symptoms. With a moderate to severe depression this is usually a period of three to six months or longer. It has been stated earlier that an adequate trial for these medications is a period of three to four weeks minimum time. Premature cessation of drug therapy in many individuals with moderate levels of depression results in immediate return of depressive symptoms and a need to return to drug management. It is then evident that the apparent state of well-being is being maintained only through the action of the drug upon which it is totally dependent.

Medications may be continued for long periods if necessary. Some of our patients have required medication in substantial therapeutic dosage for over two years. Also, shifts in medication may be necessary with maintenance dosages proving inadequate at a given period and increases in medication required. The depressed patient needs a continuing relationship with the physician and needs to be able to talk with the physician on a regular and pro re nata basis through what may be a long period of drug therapy. The patient should be encouraged to continue using the drug as long as it is needed to relieve the symptoms of depression!

Antidepressant medications are NOT (NOT!) freely interchangeable. Fatalities are reported when various monoamine oxidase medications are mixed. Recent reports stress the possible complications in mixing monoamine oxidase inhibitors with other forms of antidepressant medications. Nor, can these drugs be used in rapid succession. The authors observed a severe agitated, hyperkinetic delirium occurring in a patient who was started on a second monoamine oxidase inhibitor after the first had been discontinued for eight days.[4] These medications require several weeks before becoming effective and are sustained in the body for at least a week after discontinuance. They cannot be mixed or utilized in rapid succession.

Principles of Drug Therapy. It is evident from the foregoing that certain basic principles in prescribing antidepressant drugs are helpful for their most effective utilization.

1. These medications, though impressively useful, are slow to become effective. An interval of up to one full month may elapse before a given antidepressant medication will provide relief. The patient must know this from the start.
2. During the interval before a given medication has taken effect and throughout the entire course of a depressive illness, the doctor must have a good, open, candid relationship with the patient and must see him and talk with him often to insure against discontinuance of medication and/or the danger of suicide.
3. Tranquilizer medications are not antidepressant, although tranquilizers may be used along with an antidepressant to control symptoms of agitation.
4. Different antidepressant medications *must not* be used simultaneously or in rapid succession.

5. The physician should know one drug (or two), well, knowing adequate dosage range, toxicity, side effects, and techniques for controlling their annoying drug-induced symptoms.
6. Antidepressant medications provide only symptomatic relief and may need to be continued for long intervals.
7. The physician must treat the patient, not the symptoms nor the "syndrome." Thus, careful and continuing attention must be devoted to the general physical condition of the patient and the physician must be aware of the various physical illnesses which can produce depression such as brain tumor, abdominal neoplasms, and the like.
8. If the condition is severe or prolonged, consultation should be sought.

The decision to use an antidepressant drug is made on an individual basis. Several factors are taken into consideration in making that choice. Knowledge of the intensity of the depressive symptoms, factors in their formation and intensification, awareness of the personality of the patient, the degree of suicidal potential, and the amount of discomfort experienced currently by the patient should all be viewed. It is important to recognize that the antidepressant drugs offer only symptomatic relief and thus must be continued until the endogenous life cycle of the depression has passed. The previous therapeutic responsiveness of the patient to antidepressant drugs or other therapies to relieve depressive symptoms should be known as it substantially may alter the choice of therapy in the present illness. The present physical health status of the patient may play a role in selecting or avoiding particular drugs or using or avoiding other forms of therapy.

All of these considerations precede the knowledge of particular antidepressant drugs. The particular drug then may be selected based on the clinician's familiarity with a particular agent, the effectiveness of the drug for a particular type of depressive syndrome, ability to use it in an adequate dosage without excessively disabling side effects, avoidance of toxic effects, and finally having it effectively relieve the symptoms of depression. Through all of this, supervision of the patient must be maintained by the attentive physician and the willing patient.

The utilization of drugs which function effectively as antidepressants is of relatively recent origin. Isoniazid, a relatively toxic drug, was noted by Delay in 1955 to have antidepressant properties. Its use for that purpose was followed by Loomer and associates[5, 6] in 1957. Later, reports of severe toxicity of this drug resulted in discontinuation of its use as an antidepressant by most physicians despite its high degree of antidepressant potency. At about the same time, Kuhn[7] described the antidepressant properties of imipramine (Tofranil).

Since then, a number of other drugs similar to isoniazid, which act as monoamine oxidase inhibitors (MAOI), have been introduced in the drug field.[8] In addition to isocarboxazid (Marplan), which will be described in more detail, they include phenelzine (Nardil) and nialamide (Niamid). Stimulant effects of a lower order of antidepressant properties have been noted with agents such as amphetamines, methyl phenidate (Ritalin), deanol (Deaner), pipradol (Meratran), chlordiazepoxide (Librium), meprobamate with benactyzine (Deprol) and pargyline (Eutonyl). Other potent antidepressant drugs to be described in more detail include imipramine (Tofranil) and amitriptyline (Elavil).

The three drugs to be discussed are representative compounds and relatively effective and safe ones in frequent usage in office and hospital practices. This does not mean that other antidepressant drugs may prove less effective in the hands of other physicians. As a matter of fact, there is very active experimentation in many centers in an effort to develop newer and more effective medications in this area. Drug obsolescence could be very rapid as newer compounds appear.

Amitriptyline Hydrochloride (Elavil). Amitriptyline hydrochloride (Elavil) is a potent antidepressant which is not an MAOI. This drug possesses a low order of toxicity and is unique in that it also has an anxiety-relieving component. The primary site of pharmacologic action of amitriptyline is the central nervous system, although the exact location within the brain where the drug acts is not clear. It does not have a diffuse cortical action as do many sedatives. Animal studies fail to indicate any relationship between administration of this drug and brain levels of serotonin. Some of the autonomic nervous system activity noted with its use are anti-

cholinergic effects, antihistaminic activity and adrenergic blocking activity.

Amitriptyline is useful in the treatment of the symptoms of a depressive syndrome and its accompanying anxiety.[9-11] Its level of potency is less than that of the other two antidepressants discussed in detail, isocarboxazid and imipramine. This means that it may be less effective in a particularly severe depressive syndrome than the other two drugs. It is, however, a well-tolerated and effective drug which is particularly useful in ambulatory patients with depression. Persons with reactive depressions, depression accompanying chronic illnesses, neurotic depressions, and mild psychotic depressions frequently respond to amitriptyline therapy.

The onset of an effective antidepressant drug response may be noted as early as three to four days after its initiation, but it is frequently longer. In certain persons it may not be prominent until a period of drug usage of four to six weeks has elapsed, and with some persons no significant drug response is noted at all. The dosage form is oral tablets, in the size of 10 or 25 mg. Uncommonly a parenteral form may be used to permit more rapid control of the symptoms through the intramuscular route. The parenteral route may be used four times daily in doses of 20 to 30 mg. for periods up to two weeks until symptoms are sufficiently controlled so that oral administration is then possible. In contrast to the delayed antidepressant drug response, the tranquilizing (anti-anxiety) drug effects are present soon following each dose.

Therapy usually is started at a dosage level of 25 mg. three times daily, with increases at increments of 25 mg. to a dosage level of up to 150 mg. daily. Under unusual circumstances in hospitalized depressed patients, it may be further increased to double that treatment level. When a therapeutic response is obtained, the dosage may be dropped to a minimum level sufficient to maintain that improvement which is frequently 50 to 100 mg. daily in divided doses. Elderly patients may have a lower drug tolerance requiring their management at drug levels of 30 to 60 mg. daily in divided doses. The presence of the tranquilizing component in the action of this drug often results in its most effective administration divided between early in the day and late in the day and evening, which may be the most difficult periods for these persons.

Prolonged usage of antidepressant drugs has not been a factor in producing addiction, although the degree of symptomatic relief obtained may lead to some dependency. When these drugs are discontinued, it should be done gradually if possible. This can be effected by cutting the dosage in half, reducing it by half again in one week, and then totally discontinuing it. This is an effective regimen for drugs taken over a long period of time. Due to their long lasting action, the continued effects of these drugs may persist for an extended period of time after having been stopped.

In general side effects are mild, and amitriptyline is well tolerated by most patients. Drowsiness is experienced frequently in the first few days of drug administration, but this disappears with continued drug usage for most persons. When given in the evening, however, the drug is of assistance to some patients with a disturbed sleep pattern. Other reported side effects are dizziness and hypotension; jitteriness, fine tremor and excitment; anorexia, nausea and heartburn; increased perspiration and skin rash; headache. High doses may induce states of confusion, excitement, or at times activation of an otherwise latent psychosis. Anticholinergic side effects include blurred vision, dryness of the throat and mouth, constipation, and tachycardia. Dosage reduction may assist in controlling these side effects.

Because of the anticholinergic effects extreme CAUTION must be exercised in using amitriptyline with persons who may have problems with urinary retention and a CONTRAINDICATION exists for persons with increased intra-ocular pressure, as in glaucoma. There may be an altered response to alcoholic intake while taking this drug; there may be potentiation of barbituates. It is not advisable to give this drug simultaneously with other antidepressants, and an interval should be permitted to elapse between giving two such agents.

Imipramine (Tofranil). Imipramine (Tofranil) is a highly potent antidepressant which is not an MAOI. It is chemically closely related to the phenothiazine drug, promazine, though its clinical activity is quite different. The site of action in the central nervous system remains unclear although certain actions are described in depression of the reticular formation, anticholinergic activity and adrenergic sensitization. It appears that the

5. The physician should know one drug (or two), well, knowing adequate dosage range, toxicity, side effects, and techniques for controlling their annoying drug-induced symptoms.
6. Antidepressant medications provide only symptomatic relief and may need to be continued for long intervals.
7. The physician must treat the patient, not the symptoms nor the "syndrome." Thus, careful and continuing attention must be devoted to the general physical condition of the patient and the physician must be aware of the various physical illnesses which can produce depression such as brain tumor, abdominal neoplasms, and the like.
8. If the condition is severe or prolonged, consultation should be sought.

The decision to use an antidepressant drug is made on an individual basis. Several factors are taken into consideration in making that choice. Knowledge of the intensity of the depressive symptoms, factors in their formation and intensification, awareness of the personality of the patient, the degree of suicidal potential, and the amount of discomfort experienced currently by the patient should all be viewed. It is important to recognize that the antidepressant drugs offer only symptomatic relief and thus must be continued until the endogenous life cycle of the depression has passed. The previous therapeutic responsiveness of the patient to antidepressant drugs or other therapies to relieve depressive symptoms should be known as it substantially may alter the choice of therapy in the present illness. The present physical health status of the patient may play a role in selecting or avoiding particular drugs or using or avoiding other forms of therapy.

All of these considerations precede the knowledge of particular antidepressant drugs. The particular drug then may be selected based on the clinician's familiarity with a particular agent, the effectiveness of the drug for a particular type of depressive syndrome, ability to use it in an adequate dosage without excessively disabling side effects, avoidance of toxic effects, and finally having it effectively relieve the symptoms of depression. Through all of this, supervision of the patient must be maintained by the attentive physician and the willing patient.

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action of this drug in the human body, and that of other antidepressants including MAOI drugs, occurs by pharmacologic mechanisms which are not yet known.

Imipramine is useful in moderately intense depressive syndromes.[12, 13] Its level of potency is comparable to that of isocarboxazid and greater than that of amitriptyline. It is helpful in some persons with more severe depressive syndromes; however, the concern about suicide in such patients may necessitate their hospitalization and often electroshock therapy due to the delayed action of this drug. The choice of antidepressant drug therapy or electroshock therapy in treatment of depressions remains a matter of individual clinical judgment as well as the preference of the clinician. In general, treatment in persons with mild and fairly typical depressions, or those which are recurrent or resistant to electroshock therapy, is started with antidepressant drugs.

In those persons where severe depressive symptoms urgently require relief due to suicidal risks or where drug therapy has been ineffective, the choice is electroshock therapy. Where a combination of antidepressant drug therapy and electroshock therapy is received, there may be a need for fewer shock treatments than would otherwise be needed. Such patients may be placed on outpatient drug therapy after the termination of hospitalization with its continued usage for a period of at least several months. Similar management has assisted some persons who have had recurrent depressions at frequent intervals to avoid that pattern of illness through continued drug usage over extended periods of time. Premature withdrawal of such drug therapy may result in immediate return of depressive symptoms, thus indicating the masking of symptoms rather than their actual removal by the drug.

There have been clinical reports of effective use of imipramine in other conditions than depression, such as obsessive-compulsive reactions, impotence, schizophrenic catatonic stupor and others, but these reports are scattered and not confirmed in the experience of other physicians. A variety of types of depressions, from reactive depressions to involutional melancholia to depressions associated with other mental disorders, all appear to be responsive in substantial measure to imipramine.

The usual initial therapeutic dosage level is 100 mg. daily in divided oral doses. Gradual increase by increments of 25 mg. may be made to 200 mg. daily if early improvement is not noted. In hospitalized patients there may be a further increase by gradual amounts up to 300 mg. daily with caution regarding side effects. Tablets are available in 10 and 25 mg. sizes. Intramuscular administration may be used in specific patients where a maximum or early response to treatment is essential. When a therapeutic response is obtained, the dosage is reduced to a maintenance level which is usually from 50 to 150 mg. daily in divided doses and is selected on the basis of minimum amount needed to maintain the level of response. The daily dosage in adolescent and geriatric patients frequently is in the range of 30 to 40 mg. initially and extending up to 100 mg. in divided doses.

All dosage is individualized and thus quite variable but ordinarily within the suggested range. The drug has a lag in the appearance of antidepressant effects which is frequently one to three weeks and may extend up to six weeks before the therapeutic response is noted. An increase in dosage does not usually shorten that time interval although the incidence of side effects rises with higher dosage levels.

Although side effects are numerous, they are usually mild with imipramine and the drug is ordinarily well tolerated. Anticholinergic side effects include blurred vision, dryness of the throat and mouth, constipation, and tachycardia. Similar to the concern about amitriptyline, when using imipramine extreme CAUTION must be exercised with persons who may have problems with urinary retention and a CONTRAINDICATION exists for persons with increased intra-ocular pressure, as in glaucoma.

Milder and often transient side effects include increased perspiration and skin rash; nausea, anorexia and vomiting; paresthesias of the forearms and hands; restlessness, tremor of the hands, and insomnia. Hypotension and dizziness is a serious problem in older patients where close observation of the cardiovascular status must be maintained. There are some reports of obstructive jaundice, epileptiform seizures, Parkinsonian syndrome, and agranulocytosis. Some of these items represent toxic responses to the drug rather than actually pharmacologic side ef-

fects and must be treated accordingly, frequently calling for drug withdrawal.

Increased psychiatric symptoms in the form of anxiety, restlessness, confusional states, activation of a latent psychosis, and a hypomanic state are produced in some patients. There may be an altered response to the intake of alcohol, and barbiturates may be potentiated in their action. This drug should NOT be given simultaneously with other antidepressants, and a minimum time interval of one week should be allowed before cautiously starting another compound in that group of drugs.

Isocarboxazid (Marplan). Isocarboxazid (Marplan) is one of the most potent of the MAOI group currently in wide use in this country and therefore representative of the group. The pharmacologic action of isocarboxazid in the central nervous system raises the brain levels of serotonin and norepinephrine through the blocking of the action of monoamine oxidase. It is not clear whether this explains the clinical efficacy of the drug, since it also has central adrenergic activity.[17, 18]

Isocarboxazid is an effective drug for the symptomatic relief of depression and depressive syndromes, although coexisting anxiety may be increased in intensity.[14–16] It is a drug of relatively high potency and therefore of use in mild to moderate depressive syndromes. Its area of utility is essentially similar to imipramine and the concern about the delay in its onset of therapeutic response is also present but to a lesser extent.

A therapeutic trial with isocarboxazid may be warranted with any depressive syndrome unless the physical state of the patient, past history of nonresponsivity to this medication or the urgency of treatment due to high suicidal potential make other treatment, such as electroshock therapy, more desirable in the individual patient. The reason certain patients fail to respond to a particular antidepressant medication when they may respond to another one is not presently known nor fully predictable. The range of depressive disorders known to respond symptomatically to isocarboxazid includes reactive depressions, the depression accompanying other medical illnesses, and to some degree involutional melancholia and manic depressive reactions.

The dosage form is 10 mg. oral tablets, and there is no parenteral form. The dosage is individualized for each patient but usually starts at 10 mg. given three times daily in a single or divided dose. The initial dosage level is usually not exceeded, but it may be reduced to a maintenance level of 20 mg. or 10 mg. daily when an adequate therapeutic response has been obtained. Combined isocarboxazid therapy with electroshock therapy or psychotherapy frequently is rendered to the patient.

The delay in clinical response is present as with other antidepressants but is sometimes of shorter duration. Some patients report improvement in one to two weeks, although it may be necessary to continue medication for three or four weeks before there are substantial signs of improvement.

Prominent among the side effects reported by patients are restlessness, over-activity, jitteriness, and insomnia which may be controlled by dosage reduction, altered time of giving the medication, or simultaneous administration of low levels of a tranquilizing drug, such as trifluoperazine (Stelazine) in doses of 1 or 2 mg. two or three times daily. Gastrointestinal disturbances such as constipation may occur. Urinary retention or incontinence, neuritis, spider telangiectases, peripheral edema, and skin rashes are complaints of some patients on this drug.

Hypotension is characteristically observed in certain patients with resultant dizziness and vertigo reported. Headache is occasionally seen as is weakness, fatigue, dryness in the mouth, and blurred vision.

This potent drug can increase anxiety and result in confusional states or in the activation of a latent psychosis. Hallucinations have been reported with a high dosage level with loss of symptoms when therapy was discontinued or the dose markedly reduced. Caution must be exercised when it is used in combination with other drugs. Isocarboxazid does have marked potentiating effects on drugs such as sedatives, hypnotics, alcohol, narcotics, ether, hypotensive drugs, and insulin. Such combinations should be used only with considerable caution, and it is preferable to reduce the dosage of isocarboxazid before beginning therapy with any other such agent which falls in the category of dubious combinations.

Elective surgery is usually performed after a four-to-five day, isocarboxazid-free interval to minimize complications with anesthetics and pre-anesthetic drugs. It

should NOT be given in combination with other antidepressant drugs, and an interval must be present between the discontinuation of the first drug and initiation of the second one. There is a low incidence of altered liver function or jaundice in patients who are receiving isocarboxazid and the drug is probably contraindicated in those patients who have a history of liver disease. Caution should be exerted in its use in patients with impaired renal function to prevent its accumulation. Patients with coronary artery disease, anginal symptoms, or recent myocardial infarction are poor candidates for this medication which may mask anginal warning symptoms.

Summary. General principles of administration of antidepressant drugs have been presented. Adequate knowledge of the usefulness, dosage, and side effects of a few antidepressant drugs helps to make them most useful in clinical practice. They may be used over long periods of time with appropriate medical observation, but individual antidepressant drugs are not interchangeable with tranquilizers nor can they be simultaneously used with other antidepressants. Three antidepressant drugs, isocarboxazid (Marplan), imipramine (Tofranil), and amitriptyline (Elavil) have been discussed in detail. They have many similarities, but they have varying effectiveness in different patients due to their particular pharmacologic properties.

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CLINICAL CENTER STUDY OF PINEALOMA

The cooperation of physicians is requested in a study of children patients with pinealoma, being conducted by the National Institute of Mental Health at the Clinical Center, National Institutes of Health in Bethesda, Maryland.

The primary purpose of this study is to determine whether pineal tumors synthesize compounds whose identification would provide diagnostic assistance to the practitioner.

Of particular interest are children who have precocious puberty or evidence of a delay in the onset of puberty (girls aged 15 who have not yet had their menarche). However, information concerning all pinealoma patients is needed in order to determine if further study would be of value.

Hospitalization of the patients in the Clinical Center is not necessary, and they will not have to be examined here. Instead, a brief medical history including pertinent information about the child's gonadal development is requested. If surgery is performed on the patient, a piece of the tumor tissue (which has been frozen soon after removal) would be useful. A urine specimen may be needed from selected patients.

Physicians who are interested in contributing information about their patients for this study may phone or write to: Richard J. Wurtman, M. D., Laboratory of Clinical Science, National Institute of Mental Health, National Institutes of Health, Bethesda, Md. 20014.

CASE REPORT

Surgical Correction of Congenital Absence of Abdominal Aorta and Iliac Arteries

By WILLIAM M. STOLL, M. D., Green Bay, Wisconsin

■ EXTENSIVE review of the literature, including the research library of the American Medical Association, has failed to establish any case of congenital absence of the abdominal aorta and iliac arteries corrected by surgery.

This report describes the case of an adult male who was found at operation to have a congenital absence of the abdominal aorta below the renal arteries, as well as absence of the iliac arteries. The arterial patency became evident at the junction of the superficial femoral and profundus arteries bilaterally.

Case Report. A 55-year-old white man was seen in consultation in April 1963. The patient's history was essentially that of severe bilateral leg weakness and claudication. He was unable to walk more than 50 feet without weakness and pain. His past history indicated he had had "leg trouble" for as long as he could recall. He had had bilateral lumbar sympathectomies performed in 1955, deriving some benefit from the surgery at that time. Physical examination revealed no palpable femoral pulses and marked evidence of arterial insufficiency in both legs and feet. High translumbar aortogram demonstrated a complete block of the abdominal aorta beyond the take-off of the renal arteries.

The patient was prepared for surgery with a preoperative diagnosis of aortic arterial occlusive disease with complete occlusion of the abdominal aorta beyond the renal arteries. Surgical exploration of the common femoral arteries was carried out first, revealing small common femoral arteries without lumens. Superficial femoral and profundus arteries were patent bilaterally. Exploration of the abdominal aortic area revealed a 3-cm. bulbus dilatation of the abdominal aorta distal to the renal artery take-off level. This dilated aorta was filled with thrombus and was not disturbed. A fibrous cord 2 mm. in diameter ran from the bulbus dilated aorta down the usual course of the abdominal aorta and both iliac arteries. The fibrous cord became more prominent as the common femoral arteries were approached but still no lumen was present until the superficial femoral and profundus arteries were reached.

The left chest was entered and a 16 mm. bifurcation Dacron graft was anastomosed to the side of the distal thoracic aorta, partially occluding the thoracic aorta while accomplishing this anastomosis. The limbs of the graft were then run retroperitoneally to the groin level and anastomosed, end to side, to the superficial femoral arteries. Dorsalis pedis and posterior tibial pulses were palpable bilaterally at the conclusion of the operative procedure.

Approximately five days postoperatively, either a pulmonary infarction or a graft infection developed. The patient was treated with continuous intravenous administration of vancomycin and penicillin for three weeks and made a full recovery. A postoperative aortogram demonstrated a functioning graft with no evidence of a recent graft infection such as the formation of a false aneurysm at the anastomotic site. The patient was discharged seven weeks after surgery. Since then he has had full and bounding bilateral dorsalis pedis and posterior tibial pulses.

Summary. The only known case of surgical correction of congenital absence of the abdominal aorta and iliac arteries has been presented. A Dacron bifurcation graft was inserted, as a bypass graft, between the distal thoracic aorta and the bilateral superficial femoral arteries, resulting in good bilateral dorsalis pedis and posterior tibial pulses.

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The Incidence of Trophoblastic Disease in Wisconsin

By F. J. HOFMEISTER, M. D. and W. R. SCHWARTZ, M. D.

Milwaukee, Wisconsin

■ HYDATIDIFORM MOLE and choriocarcinoma are infrequently encountered neoplasms. This report is an attempt to review their incidence in some areas of the world and then to compare this incidence to that in our own area in the state of Wisconsin.

A chain-like continuity of complications, starting with the benign mole with its associated history of bloody spotting, and at times hemorrhage, can be followed by choriocarcinoma, with its continued bloody spotting, chest symptoms, and rapid death. Since these symptoms in a normally pregnant patient are not unlike those encountered when a "routine" threatened abortion exists, it is essential that the physician be reminded repeatedly that this infrequent potential hazard can exist.

Once a hydatid mole is encountered, the physician cannot be complacent. He has a great responsibility for careful follow-up studies in order to detect and make an early diagnosis of the malignant status of these trophoblastic tumors. This is especially so since choriocarcinoma, once considered potentially 100 per cent fatal, now has been found to respond at times to newer methods of therapy. It has always been recognized that the diagnosis of chorioadenoma destruens offered hope for survival; now the *early* diagnosis of choriocarcinoma followed by treatment with methotrexate may mean survival. Dr. Roy Hertz[1, 2] of the National Institutes of Health has reported spectacular results of treatment of choriocarcinoma in patients formerly "doomed," and recently has suggested that in the very young patient with choriocarcinoma chemotherapy without radical surgery is a method whereby child-bearing capacity may be retained. Of 63 patients with metastatic choriocarcinoma and related trophoblastic tumors, 47.5 per cent have no evidence of disease after five years; 35 per cent died after having initial remissions; 11 per cent have persistent disease and 6.5 per cent showed no response. Previous hysterectomy played no role in the subsequent response. The urgency for early diagnosis as indicated in our preliminary statements must be emphasized, since Doctor Hertz determined in his series that 18 of 25 patients treated within four months of onset of the disease experienced remission.

Dr. John Brewer[3, 4] recently reported statistics from the Albert F. Mathieu Chorionepithelioma Registry, which he heads, and indicated that of 147 patients with choriocarcinoma, 21 survived without evidence of disease for five or more years after treatment. More recently he reported 122 cases of choriocarcinoma treated by hysterectomy of which 46 per cent of those without metastases and 19.2 per cent of those with metastases at time of surgery have survived five years or more, giving an overall rate of 31.9 per cent. The 19.2 per cent figure is much less favorable than Doctor Hertz's[1] 47.5 per cent survival of similar patients treated by chemotherapy.

An ever-present suspicion together with a sound familiarity with the peculiar actions of these lesions must be the basis for the attack. An operational base of attack is built on knowledge of incidence, predilection, and geographical distribution.

The most frequently encountered of these rare lesions is the hydatidiform mole. Most interested investigators indicate an almost uniform incidence of hydatidiform mole among white people of from 1:2,000 to 1:3,000 pregnancies.[5,11,13,15,17]

The mole is not proliferative, but a degenerative process considered by some pathologists to be "a malformation of the placenta, a result of the failure of continuing fetal angiogenesis."[5] It is characterized by dis-

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Presented in part at: (1) The American College of Surgeons, Panel, San Francisco, Calif., Oct. 13, 1960; and (2) District VI, The American College of Obstetricians and Gynecologists, Fargo, N. D., Nov. 17, 1961.

tended villi covered by a semi-permeable membrane composed of a single layer of trophoblast.

The coexistence of a hydatidiform mole with a fetus is extremely rare, since existence of a mole is incompatible with life. This coexistence has been recorded however, but there has always been an early interruption of fetal life. Ruffolo[16,7] has estimated that this coexistence occurred in approximately 1:105,000 pregnancies. Hreshchyshyn[6] quotes 0.5 per cent of all choriocarcinomas from this type of pregnancy.

Hydatidiform mole should not be confused with hydatidiform degeneration of the stroma of chorionic villi which is a "quantifiable alteration"[5] found in 10 to 40 per cent of all abortions and 10 per cent of all gestations. This condition is not significant.

There are well-documented reports which substantiate the observations of H. Acosta–Sison,[8, 9] who indicated in 1949 that there were racial variations by reporting a Philippine incidence of 1 in 145 pregnancies. The statistics from this area now have been reported to vary between 1:200 and 1:250 pregnancies.[5] It should also be remembered that these figures are taken from hospital deliveries, which actually constitute a small percentage of infants delivered in that country as a whole. The majority are delivered at homes and recorded by midwives. Therefore, this reported incidence probably is not a true incidence. However, it may be that the condition could be much more frequent since these figures represent a population from the immediate area and not necessarily referred to a center for treatment.

The work has been supported by a joint project[5] of the study of choriocarcinoma and hydatidiform mole in Asia, financed by grants from the Anna Fuller Fund and the National Cancer Institute of the Public Health Service. It was found that this high incidence occurred among people characterized as Malayan, Mongolian, and also Caucasian. Climate in the area covered by these reports ranged from seasonal to tropical. Cultural habits apparently played no part. Ages of the afflicted varied from 18 to 50 years. The group associated with the highest incidence was prolific and of a low socioeconomic level and in an older age group. Additional work will be required to substantiate these observations.

It is interesting to note that Dr. Gordon W. Douglas[5, 10] of New York University's College of Medicine, in a series of 70,000 deliveries and 15,000 abortions among Irish, Italian, Negro, and Puerto Rican patients could not detect, even in the low socio-economic groups, the high incidence of chorionic tumors reported in the Far East.

Hydatidiform mole represents the benign status of trophoblastic neoplasms. Increased anaplastic and trophoblastic activity may develop. Chorioadenoma destruens, also known as destructive hydatidiform mole, will occur in about 10 per cent of hydatidiform moles. It is not a malignant neoplasm, although clinically it has malignant characteristics. It will not produce general metastases, but some patients will die of perforation, or hemorrhage, or sepsis. Microscopically villi are identified, surrounded by masses of trophoblastic activity. This condition, because of its invasive characteristics and potential, has been likened to placenta accreta.[5]

Likened to placenta increta,[5] because of deep penetration and tenacious adherence, is the rare but death-dealing choriocarcinoma, also known as chorionepithelioma. Novak[11] states that less than 5 per cent of all hydatidiform moles have the destiny of becoming choriocarcinoma.

Freed and Chatfield[12] estimate that choriocarcinoma exists in a ratio of 1:25,000 pregnancies, with other estimates varying from 1:13,000 to 1:73,000 pregnancies. However, where people of Malayan, Mongolian, and Caucasian strains predominate as a group the incidence is much higher. H. Acosta–Sison[9] reported the fantastic number of 142 choriocarcinomas during a 10-year period.

Not all choriocarcinomas follow hydatidiform moles. Twenty-five per cent follow abortions and 25 per cent follow pregnancies. A few have been reported following ectopic pregnancies. Hertig[13] has indicated this incidence to be 1:5,333 ectopics. Freed and Chatfield[12] quote 2.5 per cent and Hreshchyshyn[6] 3.3 per cent following ectopic gestations. Instances have been reported where vaginal metastases have been discovered and death has occurred with a gestation in the seventh and eighth month.[17] This is an example of one of the many mysteries which surround the origin and transport of malignant trophoblast. Barr and Oktay[14] of Dayton, O., report a case of primary ovarian choriocarcinoma and indicate this to be the fourth recorded in medical literature.

Choriocarcinoma is a peculiar neoplasm. At times it may be characterized by deadly lesions in the lung and brain, with no evidence of the primary lesion in the uterus, when meticulously examined at autopsy. Often this metastatic lesion may present the first clue to the diagnosis. Metastases in the lung exist in approximately 40 to 70 per cent of cases, and Hreshchyshyn[6] believes that 100 per cent would show metastases if all cases came to autopsy. Metastases in the vagina exist in approximately 30 per cent of cases. Failure of early identification of these lesions by biopsy and significant x-ray findings has in the past resulted in unnecessary death due to delay of therapy.

We have toured the world geographically and have reviewed many opinions. Now, what are our statistical findings in our own area of Wisconsin?

Statistics were gathered from all hospitals in Milwaukee and also from the University Hospitals at Madison. The results are shown in Table 1.

All are hospitals which treat private patients, except the Milwaukee County Hospital, which is for the indigent patient, and where patient load is approximately 50 per cent Negro. The University of Wisconsin Hospitals serve both private and indigent patients.

The total statistics represent 374,204 pregnancies, including deliveries, abortions, ectopic gestations, and hydatidiform moles. During this period hydatidiform mole was treated 163 times. This is an incidence of 1:2,295 pregnancies, which compares favorably with the national statistics quoted previously. These trophoblastic neoplasms were all from the geographical area in which the pregnancies existed.

One of the moles developed into a chorioadenoma destruens with pulmonary metastases. Hysterectomy resulted in complete regression of the pulmonary lesion and cure. Another chorioadenoma destruens was discovered in an ectopic pregnancy (cornual) and, for a time, the diagnosis was in doubt (chorioadenoma destruens versus choriocarcinoma). The patient was finally diagnosed as having destruens and has had no recurrence.

Six choriocarcinomas followed pregnancies from the same geographical area in which the pregnancies occurred. Seven additional choriocarcinomas are listed as having been treated in these hospitals during the period when the 374,204 pregnancies were cared for. The fault of these statistics lies in the fact that in the institution with 4,377 pregnancies, 3 choriocarcinomas were treated. All 3 were referred into that hospital for treatment from an area foreign to the immediate area of that hospital.

One patient listed as treated primarily by St. Joseph's Hospital also appears in Deaconess Hospital statistics, as she was later referred there for cobalt therapy.

The choriocarcinomas treated at St. Joseph's Hospital followed hydatidiform mole in two cases (one referred there for treatment of metastatic disease); one fol-

TABLE 1—*Statistics on Trophoblastic Disease in Wisconsin*

Hospital	No. years reported	Infants delivered	Abortions	Ectopic pregnancies	Hydatidiform moles	Choriocarcinomas	
						Primary Rx	Referred In
Columbia	22	24,098	2,191	108	13	—	2*
Deaconess	18	30,105	1,629	126	8	—	1*
Doctors	14	3,647	595	83	—	—	—
Lakeview	9	3,559	323	9	4	—	—
Milwaukee County	12	15,022	2,350	185	12	—	—
Milwaukee Hospital	23	56,702	1,755	145	23	—	—
Misericordia	10	15,852	1,298	68	8	—	—
Mount Sinai	9	24,584	1,641	129	15	—	—
St. Anthony's	11	17,152	971	60	9	1*	—
St. Francis	6½	11,751	635	35	9	1†	—
St. Joseph's	13	64,751	4,791	224	32	3*‡	1*
St. Luke's	10	23,786	(Incomplete statistics)			1*	—
St. Mary's	16	29,998	1,565	129	16	§	§
St. Michael	20	21,152	1,682	81	12	—	—
West Side	3	734	109	5	—	—	—
West Allis	1	1,081	52	1	—	—	—
University (Madison)	12	4,006	335	24	12	—	3*
Trinity	3	2,328	397	2	2	—	—
TOTALS		350,308	22,319	1,414	163	6	7

*Preceded by previous pregnancy, mole, or abortion.
†Preceded by prior pregnancy but discovered only on autopsy (patient dead on arrival at hospital).
§Two cases of choriocarcinoma; one in a malignant teratoma, patient age 19, and one in an ovary in a patient age 78. (No preceding pregnancy in either.)
‡One of these cases is the same case in Deaconess Hospital statistics (referred in).

lowed delivery of twins, and the fourth followed abortion.

The case listed under St. Francis Hospital was diagnosed only at autopsy—metastatic choriocarcinoma was found on a patient dead on arrival at the hospital. She had had eight previous pregnancies and had had a recent positive pregnancy test.

The choriocarcinomas reported under Columbia Hospital's statistics were also the result of "foreign" choriocarcinomas, being referred to that hospital after diagnosis elsewhere.

The overall incidence of 1:28,785 pregnancies is comparable to the national figures quoted. The corrected incidence, which results after eliminating (as far as can be determined) the same case in different hospitals' statistics and cases referred in from areas foreign to the hospital reporting the statistics, is 1:62,367 pregnancies.

It is interesting to note that of the three choriocarcinomas treated at the University of Wisconsin Hospitals, one was primary in the ovary and did not immediately follow a pregnancy, although the patient has had a previous pregnancy. We should remember, however, that latent periods of 2½ years and 19 years, although questionable, have been reported. This case could also have been associated with a teratoma of the ovary.

Also of interest are two ovarian choriocarcinomas reported by St. Mary's Hospital: one in a malignant teratoma in a 19-year-old girl with no previous or existing pregnancy, and the other in a "girl" 78 years old with no previous or existing pregnancy. Apparently, these are not pure choriocarcinomas and are associated with existing teratomas.

During the last eight years of the period studied, Milwaukee Hospital reported the diagnosis of hydatidiform changes in 13 of the placentas associated with abortions. This is the previously mentioned entity which is not a true hydatidiform mole and is not significant. Mt. Sinai Hospital reports 5 similar cases.

Of interest is the fact that four of the hospitals reported instances of trophoblastic malignancies of the testicle; 11 in one instance; 2 in a second; 17 in a third and 1 in the fourth. It has been repeatedly indicated that the trophoblastic neoplasm is more prevalent in the male than in the female.[5]

We wish to add a note of caution. During our collection of data, we were impressed with a large number of hydatidiform moles reported in a two-year period from one of the hospitals. On examining the charts involved, it was discovered that a majority of these were actually hydatids of Morgagni, filed by error under hydatidiform moles by the record room. It is always important to review the descriptions in the charts instead of just accumulating figures.

Summary. Factors in diagnosis, incidence, predilection, and geographical distribution of hydatidiform moles and choriocarcinomas have been reviewed and general world statistics compared with those in Wisconsin.

The incidence of hydatidiform mole in our area of Wisconsin is 1:2,295 pregnancies; the corrected incidence of choriocarcinomas is 1:62,367 pregnancies.

Several fallacies and cautions in collecting the data are reviewed.

Conclusions. We wish to make a plea for all to cooperate in sending slides and reports of all trophoblastic tumors to the Albert F. Mathieu Chorionepithelioma Registry, headed by Dr. John Brewer, Chicago, Ill. Only by doing this will America be able to completely evaluate the incidence, age, race, and socio-economic status with geographical distribution as it affects these trophoblastic tumors. This should be a very possible and logical project in our United States, where almost 100 per cent of all obstetrical cases are treated in well-regulated hospitals. It is important that we make every effort to aid in learning more about these rare, fascinating, and death-dealing tumors.

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A PAP SMEAR AT LEAST EVERY THIRD YEAR

Review of the current potential for cervical cytology in Wisconsin shows that there are enough current facilities in the state if adequately and intelligently utilized, to permit each woman over 20 years of age to have a PAP examination every third year. A yearly examination is ideal and should be encouraged wherever possible but there are still 85% of the women over 20 not receiving the examination each year. Once every three years for every woman is an attainable goal. This goal is based on the presence of about 1,245,000 women over 20 in the state: on a once every three years basis, this would be 415,000 requiring examination yearly. Currently the State Laboratory does 90,000 and about 100,000 are done in private laboratories, or 190,000 yearly. There are about 55 cytologists in the state and available cytology facilities in 70 hospitals and clinics in Wisconsin. A successful program depends on greater use of local facilities where available for patients who can pay. The State Laboratory services can be best used for areas where local cytology services are not available or when a medically indigent patient is unable to obtain local service. A list of the cytology facilities available in the state will be sent on request to the State Laboratory.—LABORATORY NEWSLETTER, *The Wisconsin State Laboratory of Hygiene*, January, 1964.

DIABETES

Diagnosis of Diabetes (Q & A), J.A.M.A. 186:279, (Oct. 19) 1963.

As a screening test for diabetes, a random urine sugar, preferably 2 or 3 hours after a meal rich in carbohydrate, is superior to a sample collected fasting.

The diagnosis often is established by finding an elevated blood glucose 1 to 2 hours after meals, with or without the presence of glucose in the urine. In such an instance the glucose tolerance test becomes unnecessary, although not contra-indicated. On the other hand, a glucose tolerance test is the only way definitely to rule out diabetes mellitus at a given moment.

Treatment of Primary and Secondary Hemochromatosis and Acute Iron Poisoning with a New, Potent Iron-Eliminating Agent (Desferrioxamine-B)

MOESCHLIN, SVEN AND SCHNIDER, URS, *Bürgerspital Solothurn, Solothurn, Switzerland: New England Journal of Medicine*, 269: 57 (July 11) 1963.

The clinical value of a new, potent, specific iron-eliminating agent (desferrioxamine-B, or DFOM) was investigated in cases of chronic iron overload, primary and secondary hemochromatosis and acute iron poisoning. Until recently, the excessive amounts of stored iron in primary hemochromatosis could be eliminated only by venesection. Secondary hemochromatosis in sideroachrestic anemia, aplastic anemia (transfusions), thalassemia major, and sickle-cell anemia remained an unsolved problem.

The clinical results in 8 patients with hemochromatosis, one primary and 7 secondary, showed clearly that DFOM is the most potent and specific iron-eliminating agent known to date and during continuous treatment for a year 18 or more Gm. of iron could be eliminated.

The ideal dose is between 800 to 1,200 mg. daily in divided intramuscular injections (two doses of 400 to 600 mg.). Unlike the versenate derivative, other metal excretion is minimal and there are no toxic side effects. Only one patient in over 1,000 injections had a possible allergic reaction.

Iron in the form of ferritin is mobilized more readily than iron in the form of hemosiderin.

From guinea pig experimentation, it has been shown that if DFOM is used within a few hours after ingestion of iron it could be lifesaving in children who have acute iron poisoning. About 140 mg. of DFOM can bind 1 Gm. of ferrous sulfate (about 200 mg. of iron). Thus, if a child has taken 3 to 4 Gm. of ferrous sulfate, 8,000 to 12,000 mg. of DFOM is recommended. Eight thousand milligrams of DFOM are given in an aqueous solution per stomach tube to neutralize the ingested iron and 2,000 mg. of DFOM are given in 5 per cent levulose solution hy intravenous drip for the next two days. DFOM gives excellent results, especially if therapy is instituted early.—Reprinted from *International Medical Digest*, October 1963.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: THEODORE ROWAN, M. D.
Beaver Dam, Wisconsin

Case Presentation.* A 70-year-old white woman was first admitted to the hospital in July 1960 with symptoms of marked weakness, vertigo, and black tarry stools. She had a history of duodenal ulcer since 1925 with evidence of bleeding as shown by black tarry stools. A gastroenterostomy was done in 1925, and six months later black tarry stools again appeared. She had five episodes of bleeding since that time. The last episode was in 1960. Past history and family history were noncontributory.

On admission her hemoglobin level was 10.5 Gm. per 100 ml., white blood cell count 6,500 per cu. mm. with a normal differential count, and hematocrit reading 32.5%. A faint trace of albumin was noted in the urine which was otherwise normal. A gastrointestinal x-ray series showed a well-functioning gastroenterostomy. No definite ulcer crater was noted fluoroscopically, but a suggestion of a crater was noted on one of the spot films. X-ray studies showed no intrinsic or extrinsic involvement of the colon or terminal ileum. The patient was treated with blood transfusions and discharged with a final diagnosis of ulcer at the anastomotic site of the gastroenterostomy, with hemorrhage.

In January 1961 the patient was readmitted with symptoms of gastrointestinal hemorrhage with black tarry stools, weakness, and syncope. The present bleeding began two days before admission. She had no emesis. Blood pressure was 102/80 mm. Hg. The diagnosis was bleeding ulcer at the old anastomotic site.

The day after admission the patient went into shock from excessive blood loss. Her skin was cold and clammy, and her blood pressure dropped to 60/40 mm. Hg. She responded to blood transfusions. A gastrointestinal x-ray series revealed a normal-functioning gastroenterostomy except for a so-called "vicious cycle," with the barium from the proximal loop returning to the stomach and less than 10 per cent passing into the distal loop. The stoma was of good size. There was a small ulcer crater on the superior aspect of the duodenal cap which had not been present previously. There was no demonstrable stomal ulcer, and the duodenal ulcer was considered the site of the hemorrhage.

The hemoglobin level on this admission was 9.3 Gm. per 100 ml. and after transfusion rose to 13.8 Gm. per 100 ml., remaining at this level. Urinalyses were all normal.

On Feb. 1, 1961, a subtotal gastric resection with a posterior colic gastrojejunostomy was done with the diagnosis of bleeding stomal ulcer at the site of the old gastroenterostomy. The pathologic diagnosis was "lower two-thirds of the stomach and portion of duodenum showing chronic duodenitis, with tissue from the region of the gastroenterostomy showing scarring, chronic inflammation, and some ulceration."

In March, 1962, the patient returned to the hospital after two episodes of gastrointestinal bleeding. She also complained of some abdominal pain. Examination was normal, with a blood pressure of 120/70 mm. Hg. Her hemoglobin level was 9.6 Gm. per 100 ml., white blood cell count 6,700 per cu. mm. with a mild increase in the lymphocytes, hematocrit reading 31%; urinalysis showed a faint trace of albumin but was otherwise normal.

The patient received 10 pints of blood. A week after admission she complained of pain in her right knee. X-ray examination showed moderate degenerative joint disease of the right knee with slight narrowing of the medial one-half of the joint space. There was no evidence of old or recent fracture. A consultant advised vagotomy.

The patient was taken to surgery with a preoperative diagnosis of bleeding gastrojejunal ulcer. An abdominal vagotomy was

* From St. Joseph's Hospital.

performed. Postoperatively the bleeding stopped, and the patient improved.

In April 1962 the patient was readmitted with marked weakness and attacks of syncope. Her skin was pale. Blood pressure was 140/80 mm. Hg. Her hemoglobin level was 11.0 Gm. per 100 ml., white blood cell count 3,750 per cu. mm. with a mild increase in the lymphocytes, urinalysis normal, and hematocrit reading 34%. The patient received one blood transfusion and supportive therapy, and after a week she was discharged with the diagnosis of postoperative asthenia and secondary anemia.

In September 1962 the patient was again hospitalized. For approximately seven days she had had pain in her left forearm with swelling in the arm for approximately 24 hours. She also had some pain in her chest on the left side. Her neck and thyroid, breasts, heart and lungs were normal. Abdominal examination and examination of the cervix and uterus were normal. Blood pressure was 134/60 mm. Hg. An x-ray film showed an outlined area of osteolytic destruction at the junction of the middle and distal third of the shaft of the left ulna, which measured 3 cm. in length and occupied the entire diameter of the cortex of the shaft with thinning of the cortex; a pathologic fracture was seen across the midportion of the lesion. There was no other bone or joint pathology noted in the left radius or ulna. A chest x-ray film showed a spherical area of increased density immediately adjacent to the right hilum which measured 3 cm. in diameter and which was not present three months earlier. This was considered to represent either a primary bronchogenic new growth or a secondary metastatic nodule.

Her hemoglobin level was 9.4 Gm. per 100 ml., white blood cell count 9,200 per cu. mm. with the differential count being essentially normal. The sedimentation rate was 131 mm. per hour, and the hematocrit reading was 29%. The urinalysis showed 2+ red blood cells and 1+ leukocytes; the urine was otherwise normal. An intravenous pyelogram showed the left renal shadow normal in size, outline, and position. There appeared to be a slight enlargement of the lower pole of the right kidney with incomplete visualization of the lower pole calyces so that there could be a tumor mass in this region. A right retrograde pyelogram was normal. On consultation a urologist stated that the patient had a metastatic carcinoma involving the chest and skeletal framework, the primary site being unknown. A right lateral chest x-ray film revealed that the previously described spherical nodule lying in the anterior portion of the right hilum probably represented a metastatic nodule, not excluding the possibility of a primary new growth.

The final admission was in October 1962, with the patient complaining of hematuria and abdominal pain over the right kidney. Pain was also present over the distal end of the left humerus. The admitting diagnoses were metastatic lesions in the left ulna and right lung and a possible hypernephroma of the right kidney. On admission the hemoglobin level was 8.6 Gm. per 100 ml., white blood cell count 5,550 per cu. mm. with a normal differential count, and hematocrit reading 30%. Urinalysis showed a 4+ albumin and a grossly bloody urine. Repeat urinalysis two weeks later showed 4+ leukocytes but was otherwise normal. After another two weeks the urinalysis returned to normal except for 1+ leukocytes and a faint trace of albumin. A direct smear of the catheterized urine specimen showed large Gram-negative bacilli which were sensitive to methenamine mandelate (Mandelamine) and resistant to antibiotics.

X-ray examination of the left forearm compared with that of one year earlier showed a very slight increase in the size of the osteolytic lesion of the shaft of the left ulna. There was calcified callus around the margins of the pathologic fracture through the middle of the lesion. There were no demonstrable additional lesions of the left forearm.

An x-ray film of the left humerus showed a 4 cm. osteolytic metastatic lesion of the distal third of the shaft of the left humerus with marked thinning of the cortex. There was also irregularity of the inner margin of the cortex of the middle third of the shaft of the left humerus, considered consistent with additional early lesions. There was a 1 cm. osteolytic lesion of the left scapula just below the glenoid process. There was also an osteolytic lesion of the distal end of the left clavicle, 2.5 cm. in length, with moderate thinning of the cortex.

The patient was treated with chloramphenicol (Chloromycetin), meperidine hydrochloride (Demerol), and promazine (Spar-

ine) therapy. Her general condition gradually deteriorated, and she complained of weakness and pain in the left upper arm. A bedside chest x-ray film in late December 1962 showed a metastatic nodule in the region of the right hilum, relatively unchanged in position and size in two months. There was no involvement of the lung fields and the cardiac shadow was normal. There were now metastatic osteolytic lesions of the eighth and ninth ribs on the left side posteriorly and there were several additional, questionable, osteolytic lesions of the distal end of the left humerus as well as lesions of the left scapula and distal end of the left clavicle, without evidence of a pathologic fracture. There were several additional lesions, particularly in the acromial process and middle third of the shaft of the humerus.

In early January 1963, an x-ray film of the right knee and lower femur revealed several osteolytic lesions of the middle and distal thirds of the shaft of the right femur. There was also a single osteolytic lesion in the upper pole of the right patella. There were moderate osteo-arthritic changes of the entire knee joint. The patient had associated pain with swelling and effusion of the right knee. The patient grew weaker and deteriorated rapidly. Her temperature rose to 102 F. and remained elevated until she died in mid-January 1963 with clinical signs of pneumonia developing.

Clinical Discussion. *Dr. R. A. Damon:* This is a case of a 70-year-old white woman with bleeding in the gastrointestinal tract. She had at least 11 serious hemorrhagic episodes covering a 37-year period between 1925 and 1962. In the same time, she underwent a gastroenterostomy and a subtotal gastric resection with gastrojejunostomy and an abdominal vagotomy, besides numerous transfusions.

The protocol conveys to me a feeling that the exact site of hemorrhage was not clear or was different in every instance of bleeding. In view of this I would like to have Doctor Bayley comment on x-ray films taken of the upper gastrointestinal tract between 1960 and 1962. Before he does this, however, I would like to note that no films were taken any time following her subtotal gastric resection in 1961, and evidently she had no hemorrhagic episodes after the abdominal vagotomy in April 1962 until she died in January 1963.

Dr. H. G. Bayley: She was to return for x-ray studies but obviously never did. In her first bleeding episode in 1960, the area referred to was a stomal ulcer and was at the lateral margin of the enterostomy. At the next episode of bleeding we could not demonstrate anything at her enterostomy stoma, but there was a new ulcer crater in the end of the duodenal cap. The finding of the crater was definite. The presumption was that this was the site of the bleeding rather than the enterostomy.

Doctor Damon: Doctor Rowan, would you quote the pathology report on the specimen obtained from the gastric resection, and whether the site of ulceration was clearly defined?

Dr. Theodore Rowan: The specimen consisted of the lower two-thirds of the stomach and 3 cm. of duodenum. There was no evidence noted of any acute or chronic ulceration. There was a very mild amount of inflammatory changes and fibrosis in the duodenal tissue. No ulcer was noted.

Doctor Damon: I would like to have a report of that same operation and the later abdominal vagotomy.

Doctor Rowan: In essence, the operative report stated that examination of the entire abdominal content was made and no abnormalities were noted in the liver, spleen, kidneys, adrenal glands, pancreas, or elsewhere within the abdominal cavity. The stomach was palpated, and some thickening was noted in the region of the pylorus and an ulcer in the duodenal cap. The gastrectomy was not remarkable. The operative report of the vagotomy was similar in that no abnormalities were noted within the abdominal cavity. A gastrotomy was not performed. The gastroenterostomy stoma was noted to be thickened on palpation. The lower end of the esophagus was exposed through the opened diaphragm, the vagus nerves were identified, and 1 cm. excised from each.

Doctor Damon: Now we'll consider some of the causes of recurrent hemorrhage in the digestive tract. It is said that about 50 to 60 ml. of blood are needed to give a black tarry stool. Drug-induced melena can be caused by administration of phenylbutazone (Butazolidine) or adrenal-cortical hormones in patients with peptic ulcer. None were given here.

We have no lead pointing to a blood disorder as a cause. Even though gastritis and

esophagitis account for about 35 per cent of bleeding cases, I feel fairly secure in ruling these out in this patient because of no particular supporting evidence in the protocol.

Portal hypertension is likewise a poor consideration without hematemesis or any evidence of liver disease. There were no liver function studies done, so presumably it was not suspected by the attending physician either.

A benign polyp or hiatus hernia does not fit well into the general history or course of the disease.

Recurrent peptic duodenal ulceration, however, must be considered, since peptic ulcer accounts for melena in about 50 per cent of cases, with 75 per cent of these located in the duodenum. Recurrent peptic ulceration associated with a tremendous gastric hypersecretion with pancreatic adenoma was described by Zollinger and Ellison in 1955. Some of these tumors are metastatic. I have no knowledge of bone metastasis, being described. Was a 12-hour gastric secretion measured or a gastric analysis done? ("No.")

Carcinoma of the stomach, even with its diverse manifestations, is unlikely because of the long tenure of repeated hemorrhages and the lack of evidence of any liver involvement. There were no palpable supraclavicular nodes or rectal shelf.

Repeated intestinal hemorrhage not otherwise explained might be a sign of tumor of the small intestine, although this would be exceedingly rare. When found these are usually in the second part of the duodenum, and one would expect biliary or pancreatic involvement and possibly jaundice. This woman was never jaundiced, was she? ("No.") These metastasize to regional nodes and sometimes to liver, lung, and bones. So far then, recurrent duodenal ulceration seems the most likely cause of the bleeding with the information available.

September 1962 marked a rapid decline of our patient. She was admitted to the hospital for the first time without gastrointestinal hemorrhage, but instead with a pathologic fracture of her ulna as well as chest pain. Physical examination disclosed no significant findings of the neck and thyroid, abdomen, the cervix and corpus, the breasts, or lungs.

X-ray studies disclosed osteolytic cortical lesions of the left ulna and later films showed osteolytic lesions of the left humerus, left scapula, left clavicle, ribs on the left side, and finally the right femur and patella. A chest x-ray film showed a new right perihilar spherical area of increased density.

Radiologic Discussion. *Doctor Bayley:* We have chest x-ray films of June and September 1962, and the nodule in the right hilum was clearly apparent. It was not present on a film of March 1962, although it is conceivable that it was small enough to be obscured. On the lateral films it was in the hilar area.

Doctor Damon: Would you say that this had a typical "snowball" appearance of a metastatic neoplasm from a kidney?

Doctor Bayley: No, this was hilar adenopathy. The so-called "snowballs" are out in the parenchyma of the lungs.

We have another bedside film taken a month later that showed it. But remember my initial statement, it could well have been there and be small enough so that it was not visualized. In the intravenous pyelogram the one-minute film showed what appeared to be a little lobulation or enlargement of the lower pole of the right hilum. Then, on the excretory urograms, the lower pole was still visible, but the calyces never filled. This was promptly followed by a retrograde pyelogram which showed normal renal structure. There are many explanations for this. Anything that prevents excretion from the lower pole into the calyces could cause this. It could be an incidental finding that it did not fill at these intervals. Renal infarction, the cause of hypertension from an aberrant vessel, can prevent filling. Tumors infiltrating the cortex prevent filling. All of these on retrograde studies can show normal calyceal structures.

Doctor Damon: In your experience, how often might we expect normal radiologic findings on excretory urograms and retrograde studies in a clinical examination of a patient who has a renal neoplasm on autopsy?

Doctor Bayley: In order to visualize a renal neoplasm they must be of sufficient size to distort the calyces or the renal outline. If it distorts the renal outline, it is large enough to distort the calyces. With the retrograde pyelogram we have excluded a hypernephroma. Any infiltrating process of the kidney could still be there.

Figure 1 was the initial examination of the left ulna with its osteolytic lesion. The cortex was thin and there was bone destruction, but there was not actual destruction or

Fig. 1—Osteolytic lesion of left ulna.

Fig. 2—Osteolytic lesion of humerus.

periosteal reaction along the cortex. There was a pathologic fracture. The edges were not discrete. Along the cortex, which was thin, there was a sharp margin, but the rest of the bone had an irregular edge. This should be a secondary lesion. After 30 days she was producing callus, so that it was showing signs of healing but not too much filling in of the lesion.

At the same interval as this film (the end of October 1962), we have films of the humerus, shoulder, and the like. There are osteolytic lesions here of the distal humerus (Fig. 2), the scapula, and a lesion in the end of the clavicle. It was about this time that our reports changed, indicating osteolytic lesions instead of metastatic lesions.

A film of the shoulder two months later showed more extensive involvement, and the first of the rib lesions were now demonstrable. These again were osteolytic lesions, and there was expansion of the cortex and no pathologic fracture (Fig. 3).

Early in January 1963 a film of the femur revealed osteolytic lesions in the femur and across the tip of the patella.

Differential Diagnosis. *Doctor Damon:* In October 1962, the patient was hospitalized with hematuria and pain over the right kidney. She had further metastatic osteolytic bony lesions, and she underwent a rapid decline with terminal pneumonia. It would be interesting now to ask just one question. Was bloody urine ever visualized coming from either ureteral orifice on cystoscopy? ("No.")

It is safe to say virtually every malignant neoplasm may metastasize to bone. We are all aware, however, that carcinoma of the breast, lung, kidney, thyroid, as well as prostate, may include bony lesions. The pancreas, rectum, stomach, colon, and ovary, in that order, follow the leading five possibilities. Gischichter and Misearch have reported that one-sixth of metastatic bone tumors have no associated clinical evidence of primary

Fig. 3—Composite posteroanterior and lateral x-ray to show osteolytic rib lesions with expansion of the cortex.

growth. A physical examination should rule out breast carcinoma, since 85 to 90 per cent of patients have a lump as the first symptom. A primary lung carcinoma may sometimes involve the adrenal as well as bone by metastasis. The clinical history and findings support a metastatic lesion in the lung instead of a primary lesion.

Renal neoplasm has somewhat more to offer as a possibility. It may be the unsuspected primary lesion of a variety of metastatic manifestations. Since the metastasis may occur early and involve any tissue, the signs and symptoms may mimic any clinical disorder. Certain carcinomas of the kidney may remain latent or grow at a slow rate for a number of years, and then suddenly accelerate their growth and disseminate and cause death. The intermittent gross hematuria, the flank pain, and bony metastases would support this diagnosis. There is no support from the radiologic findings. According to urologic notes by Flocks and Culp, it is very unusual for a primary renal neoplasm to have negative excretory urograms. Renal carcinoma also is more often seen in men than women.

If the thyroid is palpably normal, this is strong evidence of a benign gland. It should be noted, however, that follicular adenocarcinoma of the thyroid readily metastasizes to lung and bone, and that it may take up radioactive iodine if tested. Hidden thyroid tumor remains a remote possibility.

Bone metastasis from adrenal tumors is rarely observed. Neuroblastomas are the most common malignant tumor of the adrenal, but 80 per cent of these occur in the first five years of life.

One more entity, which probably is included in every differential diagnosis of obscure disease, should be considered. Taking into account the anatomic location of the kidney, one remembers that the lower pole of a normally placed right kidney lies just anterior to the quadratus lumborum and the psoas muscles. Conceivably, renal involvement from an extrarenal mass, arising from this fascia or muscle, could occur. Oddly enough, a retroperitoneal neoplasm which invaded the right kidney and metastasized distally to bone would fit well with all the information we have to this point.

A sarcoma may metastasize to lung, liver and bone, as well as involve the surrounding structures. This is a difficult diagnosis to make solely on clinical grounds. A palpable mass in the abdomen would be helpful. It would probably be advisable to defer this consideration, but I am reluctant to do so.

The metastatic route may be of some importance in arriving at a diagnosis. Most bone metastases arrive by way of the venous system, either by direct invasion of the vein wall or by a longer, but just as effective, journey through lymphatic drainage to the central collecting cisterna chyli in the abdomen, then up the thoracic duct into the chest, finally emptying into the junction of the left sternojugular and left subclavian vein where it becomes blood-borne. This could be the explanation for the left-sided bony metastases in our patient.

A mediastinal lymphoma could easily metastasize in this manner. Distribution to bone is usually first seen in those bones having the most abundant bone marrow,

usually the flat bones, and then the long bones.

In summary, we have a 70-year-old woman with recurrent peptic ulceration, symptoms of urinary tract disease, and bony and solitary lung metastases. The problem resolves itself into arriving at a conclusion about the relationship between recurrent peptic ulceration, renal disease, and metastatic lesions.

It is most logical that the hemorrhagic episodes constituted a disease separate from the disease which caused her demise. And most likely this is due to a recurrent duodenal ulceration, not of the Zollinger–Ellison syndrome; although this has not been ruled out, and the triad would include the pancreatic adenoma. We have no proof of gastric hypersecretion. The neoplasm causing a bone and lung metastasis may have involved the kidney either primarily or secondarily. Primary renal neoplasm has no supporting radiologic evidence; and on the strength of the information supplied, I am going to rely on negative x-ray reports in choosing my final diagnosis.

Secondary metastasis to the kidney from an extrarenal neoplasm also has no supporting radiologic evidence, but normal excretory urograms and retrograde films speak louder against primary disease than against secondary disease from a nearby neoplasm.

My diagnoses are: (1) recurrent peptic ulceration and hemorrhage, (2) malignant extrarenal tumor, probably sarcoma, possibly lymphoma, with renal, bone and mediastinal involvement, and (3) bronchopneumonia.

Dr. W. E. Funcke: As far as radiology is concerned, are these metastatic neoplastic lesions in the bone?

Doctor Bayley: We must define what is meant by metastatic. There was a diffuse osteolytic destructive process in the bone. I am putting it this way for the benefit of the pathologist to refrain from telling you the diagnosis.

Dr. J. A. Szweda: Would you say these lesions were incompatible with hyperparathyroidism?

Doctor Bayley: No.

Doctor Szweda: Initially, my attention would be focused on the kidney because of the laboratory findings. However, with the development of the lung lesions, I would suspect that something else was going on, because I would think it extremely unusual to see this solitary lesion in the mediastinum on the basis of renal tumor metastases. I would consider a primary bronchogenic lesion, and this might be the source of the bony lesions. However, I would rationalize thus—people don't write about ulcers for a whole page without some reason. Consequently, I would agree with you about the Zollinger–Ellison syndrome. One is not confined to the pancreas in looking for tumors. Parathyroid tumors can develop for example. My vote would be for the Zollinger–Ellison syndrome, even though in a retrospective study such as this we do not have all the information we would seek, such as diarrhea, various electrolyte abnormalities, and studies for hypersecretion. I would anticipate that the primary tumor may be in the parathyroid glands, and the findings we have are due to metastases from the parathyroid.

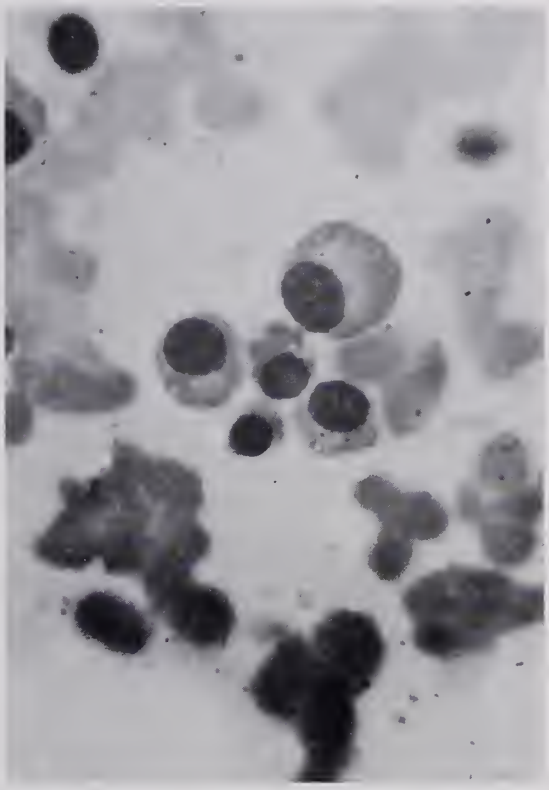

Fig. 4—Myeloma cells.

Doctor Rowan: If these x-ray studies are consistent with hyperparathyroidism, are they what you would expect to find?

Doctor Bayley: No. These could be compatible, but they are not typical, nor are they typical of the actual disease.

Doctor Szweda: This patient may have started out with hyperparathyroidism. The relationship between hyperparathyroidism and peptic ulceration has been documented over the past several years. If our patient started out this way, one would not have to call this a Zollinger–Ellison syndrome necessarily. She could have started out with hyperparathyroidism, ulceration would have been a complication of this, and then, of course, malignant degeneration of the parathyroid adenoma could have occurred.

Dr. E. R. Taake: If a bone marrow had been done, multiple myeloma could have been detected.

Pathologic Discussion. *Roctor Rowan:* At autopsy, the patient was noted to be old, very emaciated, and debilitated. She had extensive pneumonitis and pneumonia, inflammatory hilar lymph nodes, and a calcified primary complex. Careful examination for the site of a primary tumor was not rewarding. The significant findings, however, were in the multiple bone lesions and bone marrow itself (Fig. 4). This was multiple myeloma and these were fairly typical and fairly mature myeloma cells.

There were occasional binucleated forms with mild variation in the myeloma cells. The cells can vary from being mature to immature, but not a significant mixture of the two. The type is fairly well defined in any given case. The kidneys showed numerous tubules plugged with acidophilic casts, a few of which were lamellated, and occasional surrounding foreign body giant cells. The glomeruli were essentially normal.

This case brings out two or three points rather clearly. The first being that this woman had gastrointestinal symptoms and hemorrhage for many years; and as this was her principal complaint for many years, it was given due emphasis in the protocol. Examination of the gastrointestinal tract at autopsy did not show evidence of any acute ulceration; however, the stoma was consistent with a healed stomal ulcer. Despite the fact that one is always encouraged to reconcile all findings with one diagnosis, I believe that in people past the age of 70 years you should always look for two diagnoses!

At the time she came in with her bone pain and other complaints, there was no evidence of hemorrhage; and yet she was still quite anemic. She also had an extremely high sedimentation rate, and this in itself suggests perhaps some dysglobulinemia for which there might be a variety of causes.

If we had had serum alkaline phosphatase, calcium, and phosphorus determinations, then we could have excluded or differentiated clearly between hyperparathyroidism and multiple myeloma. In this case, there would probably have been a reasonably normal alkaline phosphatase, a mildly elevated calcium, and a normal phosphorus.

Dr. W. G. Richards: Might you not expect an elevated alkaline phosphatase in the presence of such osteolytic lesions and callus formation?

Doctor Rowan: In the majority of cases of multiple myeloma, whether or not there are osteolytic lesions, the alkaline phosphatase is not significantly changed. The few cases where there is elevation of alkaline phosphatase, there usually are lytic lesions in the bone and presumably osteoblastic activity with it.

It is typical of multiple myeloma fractures that they heal well, probably because these patients do have elevated serum calcium levels. One of the few diagnostic points in this case was that she complained of pain with osteolytic lesions and pathologic fractures—although not all the painful osteolytic lesions were fractured and these lesions may be painful without being fractured. The osteolytic lesions are usually clear-cut and "punched out."

Doctor Bayley: Except in this case.

Doctor Rowan: Ninety per cent of these patients do complain of pain at the site of the osteolytic lesions, and about two-thirds of them will have spontaneous fractures. About 30 per cent of these patients who complain of pain do not have any fractures.

Dr. R. F. Boock: Many times the person will go along without any complaint and then go through some minor difficulty, a cough, perhaps, and will break a rib, or will lean on something and break an arm. This will be the first time he ever realized there was something wrong and then you look for the primary.

Doctor Rowan: This is the point that I am stressing. More often in multiple myeloma, the patient will have bone pain when he does

not have a fracture. True, if you have a fracture there, then you will probably have pain. I would also like to make a point in relation to serum globulins and Bence–Jones proteinuria. This patient put out a variable amount of protein in her urine, and it would have been very interesting to have done serum proteins and Bence–Jones protein studies. Patients who have Bence–Jones proteinuria tend to have a serum globulin level that is not elevated and vice versa. Patients who have high serum globulin levels, such as 8 to 12 Gm., have about one chance in six or seven of having Bence–Jones proteinuria. When it is less than 3 to 4 Gm., a majority of them will produce Bence–Jones protein in the urine. The reason for this is not very clear. Perhaps they combine with the higher molecular weight serum proteins and are not therefore free to be excreted, or perhaps it is variation in the product of the myeloma cells. Bence–Jones protein has a low molecular weight of about 35,000, while the so-called "M–protein" which you can see in a serum electrophoresis is much larger than this. An electrophoresis will usually show quite a sharp spike of the appropriate protein, usually towards the gamma globulin or between the gamma and beta globulin levels, but does vary. In other diseases it tends to be more flattened and may have a characteristic pattern. An electrophoresis may be very helpful, even when the total serum proteins are normal. Renal insufficiency is much more likely in the presence of Bence–Jones proteinuria.

If this patient had had protein examination and electrophoresis, Bence–Jones proteinuria checked for, and a bone marrow, there would never have been any problem. The urine lactic dehydrogenase we now have available would have been a useful screen for a renal neoplasm. Because of her many episodes of bleeding and then suddenly producing osteolytic lesions, it was tactfully suggested that perhaps she had a carcinoma of the stomach which we had not seen when we examined the stomach.

Doctor Richards: That is a good point, and I was asked to review my slides. I had slight trepidation when I reexamined them and found nothing. Would the radiologist discuss the bone lesions in the light of the pathologic findings?

Doctor Bayley: The typical lesion in multiple myeloma is a multiplicity of sharply circumscribed, punched-out lesions, usually seen first in the ribs or skull or other flat bones, including the ilia. The first visible lesion on this woman was in a long bone. This would be a lead in the wrong direction. It was not punched out, the edges were not sharp, and it was localized. The lesions that eventually showed up in the humerus could well be multiple myelomas but by then we were thoroughly misled. The lesions that eventually showed up in the ribs were not typical of multiple myeloma, because it is rare to get the expansion of the cortex that we saw in her ribs and very few ribs were involved. A logical explanation could be that the mediastinal lesion was a bronchogenic tumor that eventually showed up, and these could all well be metastatic lesions from a bronchogenic tumor.

Doctor Rowan: Palpable bone plasmocytomas have been reported in up to 25 per cent of patients with multiple myeloma. One other point needs to be explained. Why did she have all her renal symptoms? Most people who have multiple myeloma have renal symptoms, and these may be quite severe. Precipitation of Bence–Jones protein in the distal tubules or in the cytoplasm of the cells lining the distal tubules occurs and there are numerous casts from coacervation of colloid in the distal tubules, and this may produce a generalized blockage. However, investigation in the last 10 years has shown that this is not purely a blockage phenomenon, because these individuals all show reduced glomerular filtration and reduced plasma flow. Only about 10 per cent show paramyeloid infiltration. I am reluctant to say why the intravenous pyelogram did not function. I would not have supposed from a histologic point of view that there would have been a significant degree of obstruction of flow through the kidneys. In your experience how often do you find this in someone who has multiple myeloma?

Doctor Bayley: Usually the pyelogram is completely normal. This could be an incidental finding, or just lack of filling at the intervals the films were taken. This is the reason that we have follow-up retrogrades. If the myeloma was the cause of her gastric hemorrhage, would there be plasma cell infiltration in the gastric wall mucosa?

Doctor Rowan: It is most unlikely, but diffuse involvement of the gastrointestinal tract with paramyeloid occurs, or may be

primarily localized to the arteries. There is very frequently an associated bleeding tendency and this is usually due to a prolonged thrombin time, and this is related to the dysglobulinemia. I do not believe that the patient's multiple myeloma had any relationship to the gastrointestinal bleeding, which had been going on for many years. I am sure her gastrointestinal lesions were due purely to local pathology with peptic ulceration. Her final bleeding may have been due to reduced thrombin time plus local renal changes. The majority of these patients die with cachexia, anemia, and bronchopneumonia.

Pathologic Diagnoses. The pathologic diagnoses were (1) multiple myeloma with renal involvement, cachexia, and anemia, (2) recurrent peptic ulceration, (gastrectomy and vagotomy), and (3) bronchopneumonia.

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one of a series

ROENTGEN RIDDLE....

The patient is a 76-year-old white man who entered the hospital complaining of early satiety, a 30-pound weight loss in three months and a noticeable mass in the epigastrium. There was no nausea and no vomiting. Surgery was performed.

Prepared by Daniel J. Price, M. D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M. D., radiologist, Department of Radiology at Milwaukee County Hospital.

ANSWER on page 258

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Analgesics for the Relief of Pain

II. NONNARCOTIC ANALGESICS

By RICHARD I. H. WANG, M. D., Ph. D., Wood, Wisconsin

■ ALL POTENT ANALGESICS at present are addicting. Even with the continuous and ardent search, not a single nonnarcotic analgesic has been found to be highly effective. In the meantime the practicing physicians are confronted daily with the problem of selecting suitable analgesics for their patients with pain.

Management of acute pain is relatively simple. Control of chronic pain, however, is difficult and frequently unsatisfactory. Because great caution should be exercised in the use of narcotic analgesics in patients suffering from chronic pain of nonmalignant etiology, the demand for effective nonaddicting analgesics is indeed great and pressing.

II. Nonnarcotic Analgesics probably act peripherally by interfering with the perception of pain. They do not affect mental alacrity and do not produce the undesirable effects of narcotic analgesics, such as respiratory depression, tolerance, physical and mental dependencies. They are usually administered orally and may be classified as follows:

A. Salicylic Acid Derivatives represent acetylsalicylic acid, sodium salicylate, salicylamide, and several new preparations such as choline salicylate and calcium acetylsalicylate carbamide.

Acetylsalicylic acid or aspirin is the most widely used analgesic. It is absorbed as the nonionized form in the stomach. It is now recognized that the use of buffer or sodium bicarbonate does not improve the absorption of aspirin from the stomach. Furthermore, when sufficient bicarbonate is given the urine becomes alkaline. Reabsorption of aspirin in the renal tubules is diminished, therefore, and the blood level of aspirin is not effectively maintained.

The usual analgesic doses vary between 300 mg. (5 gr.) and 600 mg. every three to six hours. The average duration of analgesia is approximately two hours depending upon the severity of pain. The untoward effects are dyspepsia, nausea, vomiting, symptomless gastrointestinal blood loss, pruritus, urticaria, and hypoprothrombinemia. Toxic doses, accidental or suicidal, produce at first respiratory alkalosis and then metabolic acidosis. Aspirin also has antipyretic, uricosuric, and antirheumatic activities.

Salicylamide, available over a hundred years ago, has only recently been used as the active analgesic in some newer proprietary preparations. Along with other new salicylate preparations there has been no conclusive evidence that they are clearly superior to aspirin. Enteric-coated sodium salicylate in tablet form causes the least amount of bleeding, and therefore can be given to rheumatic subjects who have a history of peptic ulcer.

B. Aniline Derivatives include acetanilid, acetophenetidin and their metabolite, acetaminophen.

Acetophenetidin or phenacetin is less toxic and has less tendency to produce methemoglobinemia than acetanilid. Phenacetin and acetaminophen have similar analgesic activities to aspirin. They are not known, however, to produce gastrointestinal

Part I on Narcotic Analgesics appeared in the March 1964 issue.

bleeding. Prolonged excessive usage of phenacetin has been reported to cause hemolytic anemia and renal papillary necrosis. Even though there appears to be no cause for alarm over the popular use of aspirin-phenacetin-caffeine (APC) compounds, there is an increasing tendency toward substituting the less well-known acetaminophen for phenacetin in proprietary preparations.

C. *Pyrazole Derivatives* consist of antipyrine, aminopyrine (of historical interest only) and phenylbutazone.

Phenylbutazone (Butazolidin) has analgesic antipyretic, antiinflammatory, and uricosuric properties, and is, therefore, used in the treatment of rheumatoid arthritis, ankylosing spondylitis, and acute gouty arthritis. Its undesirable effects, such as salt and water retention, dyspepsia, peptic ulceration, skin rashes, and agranulocytosis, greatly lower its value over other agents. Caution with frequent observation should be exercised on its long-term use, even though toxicity is less common at a maintenance dose of 200 mg. daily.

D. *Miscellaneous Mild Analgesics* include a variety of chemical compounds with low addicting liability.

1. *Dextropropoxyphene* (Darvon) is perhaps less potent that codeine, but it has a lower incidence of side effects such as nausea, vomiting, and dizziness. In order to avoid the use of narcotic analgesics in the control of chronic pain, it is popularly used in combination with aspirin or APC compound. The usual oral dosage is 65 to 100 mg. every four to six hours.

2. *Ethoheptazine* (Zactane) suffers the drawback that very little clinical work has been reported for this drug. Whether it is as effective as dextropropoxyphene or codeine remains to be proved.

3. *Methopholine* (Versidyne) has just been placed on the market. Early clinical trials claimed that it has analgesic potency equal to that of codeine. The recommended oral dosage is 60 mg. every four to six hours with or without aspirin. More clinical studies are needed to ascertain its analgesic value and side effects in patients with chronic pain.

4. *Win 20228* or pentazocine is a narcotic antagonist in the benzomorphan series. It is not yet on the market. Preliminary studies have shown that it is an effective nonnarcotic analgesic. Recent reports, however, indicate that it produces respiratory depression similar to that of morphine. More work is needed to clarify its value.

5. *Muscle-Relaxants* such as phenyramidol (Analexin) and carisoprodol (Soma, Rela) are claimed to possess mild analgesic property. Controlled clinical studies are lacking to substantiate this claim.

The ideal analgesic has not been found. It is possible that a potent nonnarcotic analgesic may be discovered in the near future.

ROENTGEN RIDDLE *continued from page 256*

ANSWER

At operation a spherical tumor 15 cm. in diameter was found. The gastric mucosa was intact. The muscularis externa was continuous with the mass. The tumor mass consisted of spindle cells with scattered hyalinization and calcification. There were no metastases. The diagnosis was leiomyoma of the stomach.

As the tumor arises from the outer layers of the stomach it is difficult from the x-ray standpoint to distinguish this from an epigastric mass separate from the stomach. The spotty calcification seen within the mass in this case is a finding which suggests that this is a gastric leiomyoma. This point has recently been emphasized by Doctors Krummy and Juhl from the University of Wisconsin. (American Journal of Roentgenology and Radium Therapy 87:727–728 [Apr] 1962)

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SPECIAL TO THE JOURNAL

A Great University and Its Student Health Program: An Evaluation

By ROBERT C. BUXBAUM, M.D.
and PETER L. EICHMAN, M.D.
Madison, Wisconsin

■ THE UNIVERSITY OF WISCONSIN, well into its second century, finds itself with the problem of educating increasing numbers of young people. Committed firmly to the policy of admitting any qualified Wisconsin resident, as well as certain out-of-state residents, Wisconsin will soon face an enrollment in excess of 30,000 students on the Madison campus alone. The University sets certain standards for students, notably in the fields of academic performance, physical education, housing, career selection, to some extent morals, and health. The last of these has been the subject of a continuing dialogue, occasionally violent, for more than half a century.

An Historical Perspective. Student health services in the United States were brought into being and nourished by departments of physical education.[1] In many cases, American universities of the nineteenth century adopted mass physical education techniques previously used in Europe; to these departments were often attached physicians whose function was to perform routine physical examinations and to care for injured students. A small infirmary was sometimes maintained to isolate cases of infectious disease.

Although student health services in the formative era were dominated by an almost mystical reverence for concepts of physical conditioning originating in Germany, forces were present which helped bring about the transformation of these organizations into more recognizable models of medical care centers. One of these was the realization by universities that absences from class, and therefore lost educational potential, were due more often to illness than to idleness or lack of interest. In 1901, following a survey of the causes of absences from class, the University of California originated a comprehensive medical service.[1]

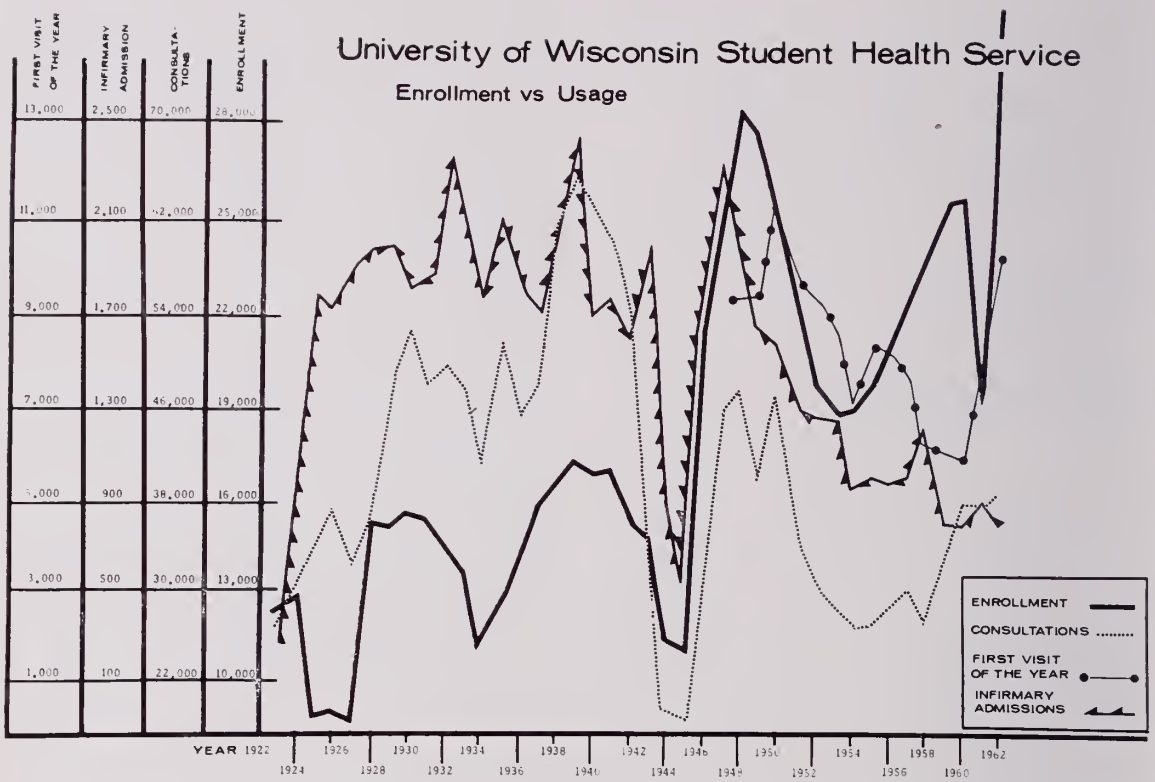
A second, more compelling reason was the presence on several campuses of epidemic disease in the early part of this century. A typhoid epidemic in 1903 caused Cornell University to begin health services to students. In 1909 the University of Wisconsin called Dr. Joseph Spragg Evans from Philadelphia to head a new Student Health Service as the direct result of an epidemic of typhoid fever, originating with a carrier who worked as a student waiter in a boarding house. Several of the 5,000 students then enrolled died, and the University, now uncomfortably aware that students living in crowded, often substandard conditions, had no services to oversee their medical care, acted quickly to remedy the situation.[1,2]

A third factor generating change in student health services was the vision and hard work of Dr. Edward Hitchcock, Jr., of Amherst College, where the first student health service was founded in 1860. This remarkable man was the first in the United States to appreciate the impact of preventive medicine and the effectiveness of public health measures in the college setting.[3] Indeed, it was Hitchcock who first applied scientific measurements, such as anthropometric data, to student populations. Hitchcock was interested in the prevention of mental disease among students, and in 1886, in the smoking habits of Amherst undergraduates, which he detailed statistically.[3] He spoke and wrote copiously of his ideas on student hygiene, and from his 51 years of service at Amherst have come many of the present concepts, now greatly modified, of student health. If there is a philosophy of student health, it should be credited to Hitchcock.

The Conflict at Wisconsin. Student Health became an issue at Wisconsin at a time when the Medical School, under Dr. Charles R. Bardeen, was attempting to expand in several directions. The school was then a two-year affair, founded in 1907. The students generally went from Wisconsin to schools in Illinois and Michigan, most notably Rush Medical College in Chicago, as well as to the University of Pennsylvania in Philadelphia and Washington University in St. Louis. There had been much talk of the development of a four-year medical course in Madison, vigorously opposed by the Dane County Medical Society; and as Student Health, the only clinical department, grew, the issues of Student Health and the Medical School became inextricably entangled.

In a letter dated Jan. 12, 1910, to Dr. Edward Evans of La Crosse, a member of the Board of Regents, Doctor Bardeen outlined plans for the new service. Rather than impose an additional dollar fee to be designated as a health fee, he told Doctor Evans, the University should simply raise the incidental fees. This would have the dual effect of

Doctor Buxbaum is an Instructor, Department of Medicine, University of Wisconsin Medical School; and Doctor Eichman is Associate Professor of Neurology and Medicine, and Director, Student Health Service, University of Wisconsin.



Graphic representation of enrollment at the University of Wisconsin (heavy line) compared with Outpatient Consultations, Infirmary Admissions, and First Visit of the Year. First Visit figures were begun in 1946; they are shown as an indicator of true student usage in the antibiotic era, since many repeat visits became unnecessary at this time. Note the decline in usage compared with the rise in enrollment in the postwar period.

preventing the student from thinking that all medical care could be obtained through the University, as well as placating the fears of local physicians about "contract practice." The new Director of Student Health was to hold regular office hours, treat minor illnesses and injuries, and give "general advice." He was not expected to call regularly at the homes of students who could afford private care, but was to see them once in order to be sure they were receiving proper care. He was to see all those who could not afford private care. In a remarkable letter of Dec. 8, 1909, to Dr. John M. Dodson, the Dean of Rush Medical College, Doctor Bardeen stated his position regarding the establishment of a health service. "I think," he wrote, "the Regents can see as little reason why they should not hire a physician to look after the students at the students' expense any more than they should not put up dormitories for students because it would interfere with the income of keepers of student rooming houses and boarding houses. They look upon the university as a state and not a city institution, and do not feel that the Madison physicians have a right to object on personal financial grounds to measures taken by the Regents for the welfare of the student body." Dodson had objected to "contract practice" as it was exemplified by Student Health, and Doctor Bardeen answered that it was bad only if the physicians were paid too little for too much work.

Bardeen went on to explain: "It seems to me the time is likely to come when most people will insure themselves not only against death and accidents but also against sickness, and the tendency will be for the big insurance companies to look after the health of the person insured against sickness. If this time should come, the physician's duty will be primarily to prevent people's getting sick rather than (as) it is now to be called to help a person out of trouble when he is so far gone that it is difficult to do much for him. . . . The transition will doubtless be hard on many individuals, just as the transition from handmade work to machinery has been hard on many individuals. . . . If there is a transition from the methods of private practice of today to general hospital and contract practice mentioned above, there will doubtless be a loss of that finer personal touch which the best family physicians have with their patients today; and this loss will probably be more than compensated by having greater scientific treatment given to the great mass of individuals."[2]

The pattern of medical practice has changed so drastically in the direction of Doctor Bardeen's predictions that his statements, half a century later, appear remarkably pertinent.[4] The fact that this controversy raged for years over the establishment of a student health service in the first decades of this century is most enlightening in view of what has developed in American medicine since then.

The Wisconsin Student Health Service became operative in spite of local objections and much unfavorable publicity in the local press. In 1910, Dr. Joseph Evans, the first Director, saw 30 to 40 students per day. In the years 1910–1911, it was reported to the Regents, Doctor Evans was overwhelmed with nearly 19,000 consultations. In 1911, there were four physicians on the staff, including Evans; and in 1912, the staff consisted of seven physicians, two nurses, a laboratory technician and several student employees. The total budget was about $16,000 per year. Bardeen saw the function of the Student Health Department as uniquely preventive in scope, in comparison to work being done at other universities. He defined this type of preventive medicine as: (1) personal hygiene, (2) the detection of constitutional defects and chronic disease, and (3) the treatment of acute illness with a view toward teaching undergraduates to recognize symptoms and to realize the value of seeing a physician early in the course of a disease. This, to Doctor Bardeen, had the value of preventing lifelong complications of disease and of avoiding epidemics among the university community.

On Sept. 21, 1914, a notice appeared in the Madison newspapers which stated that citizens of the state had repeatedly questioned the University policy of devoting its laboratories and staff to the service of students alone. Henceforth, the article stated, patients might be referred to the Student Health Service physicians by a family physician, "whenever practical," the fees received to go to the University Bursar. Indigent patients were to be treated free.

Earlier, in May, 1914, the Dane County Medical Society charged that the Student Health Service physicians were interfering with the practice of local physicians, and complained of "partiality" in referring students to specialists in Madison.

However, early in 1915, greater difficulties arose when the so-called "Bennett Bills" were introduced in the State Senate. These had the effect of curtailing the Student Health Service, of limiting the Medical School to two years, and repealing appropriations for a physics building. The legislative hearings were marked by vituperative personal accusations, with Doctor Bardeen and members of the University faculty and administration opposing the bills on one side, and Madison physicians, notably Drs. Louis Head, C. S. Sheldon, and A. G. Sullivan, with Senator Bennett, the bill's sponsor, on the other. Those supporting the bill argued that the Student Health Service excluded most Madison physicians from their referral panel, and that members of the Medical School had accused local physicians of being "dirty and reckless." The unpleasantness exposed by this uproar took many years to subside, but the Bennett Bills were modified and finally defeated, and the Student Health Service and Medical School passed their largest hurdle.

There is nothing particularly new or unusual in this situation of conflict between a medical faculty and a group of local practitioners,[5] but this particular series of events had significance for the University of Wisconsin, for it was from the Student Health Service that the Medical School, in 1925, formed its Department of Clinical Medicine, with Dr. Joseph Evans appointed as first Professor of Medicine. The local critics were, of course, correct in their predictions. The school was in fact expanding. What had begun as a service to students was now a service to the citizens of the state of Wisconsin.

Present Status and Problems. In 1932, the Infirmary was equipped to handle 110 inpatients and had outpatient offices for a dozen physicians. At that time there were approximately 10 full-time staff physicians serving a student population of 8,423. As the Medical Center expanded at a rapid rate, becoming a complex of hospital buildings and basic science laboratories staffed by an ever-increasing number of clinical specialists and scientists, the Student Health Clinic barely maintained its status quo. Against a background of an explosive postwar growth in the student body, the clinical staff declined in number and the physical plant aged and decreased in size as far as student use was concerned. For example, from a peak of 22,000 square feet used by the Student Health Service in 1932, there was a decline to the present 7,500 square feet. As it is well known, the student population has increased to 22,500 during that period of time.

At present, the inpatient space specifically designated for students is one-half of the former level and the outpatient space is at an all time low of 5,000 square feet. The acceptability of the present operation has rested on the greater use of the specialists on the University Hospital Staff and the cooperation of the present hospital administrative in supplying beds anywhere if needed. Such a liaison can not serve as the principal answer to inadequate facilities and an overworked outpatient staff.

Despite these serious shortcomings in the staff and facilities, the Student Health physicians have done yeoman service in attending the students. For example, in the year 1961–1962, 40,000 outpatient visits were made. Inpatient care of about 6,500 inpatient days, 5,500 hours of psychiatric counseling, and medical needs of 1,000 athletes, including coverage of major sporting events, were provided to the student body. Since the vast majority of these services were provided during nine months of the year, the Student Health physician is to be commended for carrying a very heavy burden and doing a reasonably good job despite the shortcomings. It

The Student Health Clinic, University of Wisconsin, Madison, prior to remodeling in 1963.

must be evident that, because of the limitations of the staff and facilities, all attention focuses on the care of the *ill* student.

Goals and Responsibilities. In the area of Student Health, the time of clear cut decisions seems at hand. The service carries a heavy load as well as it is humanly possible; it cannot continue at its present level in the face of an ever-increasing student population. Additional physicians and more space would seem logical. However, there are deeper questions involved here.

In order to approach the problem of student care, the goals and responsibilities of an ideal college health service must be defined. These embrace the following:[8-9]

1. The medical care of acute and chronic diseases which may impair the student's ability to respond to the educational process.
2. The prevention of disease through many avenues of activity ranging from immunization programs, proper housing, food preparation, and screening of students from foreign lands with high endemic disease rates.
3. Education of the young adult in the preservation of mental and physical health. Lectures, seminars, informal small group counseling in the multiple aspects of campus living, and family formation.
4. Coordination of various activities within the University which have to do with environmental health; e.g., safety committees, radiation hazards, etc., as they reflect on health needs of the student.
5. Research into improving methods of coping with student health problems.

Other Universities. In other universities of similar size and background, these goals are achieved in an impressive style. In some, complete spectra of medical and surgical specialties including dental and eye care, organized immunization programs, vigorous mental health educational courses, and more traditional public health services for the campus are provided. Wisconsin can be compared, for instance, with two college health services in midwestern land grant universities:

University "A" serves a student population of 29,000 total including a subsidiary campus in an adjoining city which contains about 5,000 of the 29,000. The student health service is an independent service located in close proximity to the university hospitals. It shares many characteristics common to the University of Wisconsin in that sense. It is supported entirely by student health fees which are collected at a rate of $12 per quarter, or $48 for an entire year. The health service is staffed by 23 physicians on a full-time basis and also employs the services of about 50 consultants. It provides dental care, eye examinations, as well as all other types of medical and surgical specialties. These are provided at no additional cost to the student beyond the health fee. Outpatient facilities at this school are housed in a four-level building containing 102,000 square feet. A significant portion of this building is devoted to specialty clinics. X-ray examinations and development are also done in this building. Laboratory facilities for the commonly done blood and urinary determinations are also housed there. The inpatient service is located in the university hospitals and is flexible as far as size goes. It is similar in many respects to the arrangement at the University of Wisconsin. The budget for this operation is approximately 1.5 million dollars and is supported almost completely by student health fees. The use of this facility is widespread. It is estimated on surveys done by this health service that 90 per cent of the student body use the clinic voluntarily. There is an average of 4.5 visits per year on a voluntary basis per student. For these purposes, they have excluded involuntary visits such as required tuberculin testing or chest x-rays.

At University "B" there is a somewhat different type of student health service. It is located far away from the medical school and therefore relies more heavily upon the private practitioners of the local community area to provide specialty services. Nonetheless, it does provide an outpatient service which is housed in an area of approximately 30,000 to 35,000 feet and staffed by 23 full-time physicians. It has 10 part-time consultants who come to the clinic and provide these services; for example, dermatology and orthopedics. The service also has a hospital with 150 beds which functions as an infirmary and in which no surgery is performed. For this purpose students are hospitalized in a local hospital. The budgetary support of this university's facility is more difficult to measure since the university has an obligatory insurance program for which it collects the premiums and from it derives benefits when the student is hospitalized in the infirmary. Allowing for corrections for these factors, the estimated cost of student health at this university is approximately one million dollars per year, of which three quarters of a million are directly budgeted in the university budget for the maintenance of the hospital and the payment of the salaries. The use by the student body exceeds 65 per cent, and the average is 3.5 visits per student per year.

In order to understand Wisconsin's Health Service in comparison with these, the present facility encompasses about 5,000 square feet for outpatients, the services of 12 physicians, some of whom are part-time, for an effective total of 9 full-time physicians. There is no impressive complement of part-time specialist consultants. One of the staff is a pediatrician who handles the children of undergraduate students.

It must be obvious from a review of these facts that the University of Wisconsin is lagging far behind in the amount of space, staff, budget, and services rendered to the student in the Student Health Program. Wisconsin has delegated, to a far greater degree than other land grant universities in this area, the cost of medical care to the students on a private basis. It is not surprising that the use of our clinic averages 1.9 visits per student, which is substantially below the "A" University's 4.5 and "B" University's 3.5.

The figures also tell another part of the story: Wisconsin is straining to keep up with medical care and must of necessity bypass the development of other desirable activities.

In April 1963, the Director spoke before the Board of Regents. The following is a portion of his speech, embodying a set of recommendations:

"In my view the University of Wisconsin has the potentiality of developing the finest health service in the United States. We have many intrinsic advantages over other college health services by our close association in a university medical center and our administrative relationship to the Department of Medicine. There are some urgently required important changes, however, which must be implemented. In order to achieve our true potential, the following proposals are now under consideration.

The Student Health Clinic after remodeling.

1. The construction of outpatient facilities of approximately 30,000 square feet. These facilities should include the administrative offices, specialty clinics, radiographic equipment for routine films and laboratory facilities for routine work, in addition to office space for 20-odd physicians. We must anticipate a growing student body and allow for an 'overbuilt' state for a few years. It is recommended that this outpatient facility be constructed in such a way that it can be expanded or added to without expensive structural changes to accommodate an even greater student body. It also could be dovetailed with the plans of the medical center for expansion of outpatient facilities in general.
2. The construction of emergency room facility which will operate on a 24-hour basis to be fully staffed with medical and surgical personnel and under the combined administration of surgical and medical departments. This must be integrated with the University Hospitals.
3. An increase in the present staff of physicians to support a total of 15 physicians is presently needed. This could represent a complement of part-time physicians with appointments or full-time student health physicians. An increase in the civil service personnel would seem urgently required if there is an expansion of our present facilities. This would include an appropriate number of receptionists, secretaries, technicians and the like. The overall operation of the student health should be in the range of $800,000 to $900,000 if all of these goals are realized.
4. However the budgetary and financial aspects of Student Health are arranged, they should include a feature which would permit the flexibility in the use of the funds with special emphasis on change in the budget according to the increase in the student population. It would be a mistake to place a strait jacket on any aspect of the budget in the face of pro-

jected substantial increases in the student population.

5. Environmental health projection in the form of coordinating in collaborative effort with other parts of campus activity should be established. This would require no expansion in the present projected personnel or budgetary needs expressed above.
6. A review by the University Administration of the insurance program which is now being offered to the students through the Wisconsin Student Association to properly integrate this aspect of student life with the overall student health need."

Recent Developments. As a consequence of the Regents' meeting, several important steps toward improvement of Student Health Services were made. Basic to all reform was the increase of the Health Fee from $5 per semester to $12. This provides for a yearly budget of $600,000 as compared with the previous $375,000. An increase of staff of 20 per cent is now planned. The use of the Student Clinic and Infirmary is expected to increase. Several research projects are underway, and the use of the Department for teaching purposes is to be strengthened. In the future, the Service looks forward to expansion and new construction of its physical plant, the addition of a comprehensive preventive medical program and closer links with those divisions of the University concerned with student life and activities.

The Student Health Department is a service to young citizens of Wisconsin. Its function is to assure the State and student of the least possible disability and loss of educational potential in the population it serves. Beyond that, it can serve in a general way as an example to our young people of the best kind of medical care. It deserves the keen support of the medical profession of Wisconsin.

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University Hospitals (6).

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NEW MEDICAL HISTORY AND EXAMINATION FORM FOR UNIVERSITY OF WISCONSIN STUDENTS

THE WISCONSIN Student Health Department is the first student health organization, so far as is known, to use the procedures described in this article. With the University population increasing rapidly it becomes ever more important to use more efficient methods of ensuring the health of the University community.

The new medical form (Figs. 1 and 2) is a first attempt to use automated data processing procedures in screening incoming students at Wisconsin. Its ultimate usefulness remains untested. Wisconsin physicians will begin seeing this form in the hands of incoming University students this year. It is hoped that the new forms will both simplify the job for community physicians and strengthen the University's medical program for students.

* * *

All students entering the University of Wisconsin for the first time are required to have a medical examination at their own expense prior to admission. Revision of the student's personal, family, medical history, and physical examination form, has just been completed. Not only does the form provide more complete medical background, but the new layout will enable the Student Health Department to retrieve the information readily. Most of the information will be recorded in punched cards by means of a new piece of equipment, the IBM Optical Mark Page Reader.

The data which will be read must be recorded by pencil marks in the labelled and defined locations. For example, the physician finding albumin in the urine would mark the appropriate response position as shown: URINALYSIS ==== ABNORMALITIES ==== ==== ==== The machine detects marked information by means of photovoltaic cells. Therefore care must be taken in marking the response positions. The marks should be made heavy and dark with an ordinary lead pencil (No. 2 recommended), and any erasure should be made complete. Ink and ballpoint pen marks cannot be read reliably by the machine.

One side of the form is to be filled in by the student before taking it to his physician. After reviewing the Personal and Family History sections, the doctor will record the physical examination on the second side of the form. The right column has been left blank for the physician to explain fully any positive findings, abnormalities, and recommenda-

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The new form and the procedures for processing it have been developed by Robert C. Buxbaum, M.D. Instructor, Department of Medicine, and Marjorie S. Herrick, B.A., Project Assistant, Department of Student Health, University of Wisconsin.

UNIVERSITY OF WISCONSIN

DEPARTMENT OF STUDENT HEALTH

ENTRANCE PHYSICAL EXAMINATION

ALL STUDENTS entering the University of Wisconsin for the first time are required to have a medical examination at their own expense prior to admission. THE STUDENT IS TO COMPLETE THE OTHER SIDE OF THIS FORM All information is held in confidential files in the Department of Student Health. The completion and submission of this form is a part of University registration procedure, and must be done as soon as possible.

TO THE DOCTOR: Please review the personal and family history and record the physical examination This record is useful in providing emergency care as well as background for routine medical and public health measures. We appreciate your thoroughness in completion of this form. Smallpox vaccination and tetanus toxoid immunization are strongly recommended Verification of freedom from tuberculosis is also important.

Peter L. Eichman, M.D.
Director

	0	1	2	3	4	DO	5	6	7	8	9
	0	1	2	3	4	NOT	5	6	7	8	9
	0	1	2	3	4	WRITE	5	6	7	8	9
	0	1	2	3	4	IN	5	6	7	8	9
	0	1	2	3	4	THIS	5	6	7	8	9
	0	1	2	3	4	SPACE	5	6	7	8	9

USE THIS COLUMN TO EXPLAIN FULLY ANY POSITIVE FINDINGS, ABNORMALITIES, RECOMMENDATIONS
(Pen may be used in this column only)

IMPORTANT

USE ORDINARY BLACK LEAD PENCIL (Not ink or ball point pen) FOR THE HORIZONTAL MARKS

BE SURE TO MAKE THE MARKS HEAVY SAMPLE

MEDICAL EXAMINATION

HEIGHT _____ ft _____ in. WEIGHT _____ lbs.

OVERWEIGHT ☐ UNDERWEIGHT ☐ NORMAL ☐

BLOOD PRESSURE _____ / _____

NORMAL (90-139 SYSTOLIC) (66-89 DIASTOLIC) ☐ ABNORMAL ☐

URINALYSIS NEG ☐ ABNORMALITIES SUGAR ☐ ALB ☐ MICRO ☐

SMALLPOX VACCINATION done at this time? YES ☐ NO ☐

TB X-RAY NEG ☐ POS ☐ TB SKIN TEST NEG ☐ POS. ☐

DO ABNORMALITIES APPEAR IN THE FOLLOWING SYSTEMS?

	YES	NO		YES	NO
HEAD, EYES, EARS NOSE AND THROAT	☐	☐	GENITO-URINARY	☐	☐
RESPIRATORY	☐	☐	MUSCULAR-SKELETAL	☐	☐
CARDIO-VASCULAR	☐	☐	NEURO-PSYCHIATRIC	☐	☐
GASTRO-INTESTINAL	☐	☐	METABOLIC	☐	☐

IS HE UNDER MEDICAL CARE? YES ☐ NO ☐ IF YES, WITH WHOM? PHYSICIAN ☐ PSYCHOTHERAPIST ☐ OTHER ☐

HAVE YOU KNOWN THIS STUDENT MORE THAN 1 YEAR ☐ LESS THAN 1 YEAR ☐ OR IS THIS HIS 1st VISIT ☐

RECOMMENDATION FOR PHYSICAL EDUCATION, INTRAMURALS, ROTC

ANY ACTIVITY ☐ ANY EXCEPT SWIMMING ☐ LIMITED (EXPLAIN) ☐ NO PHYSICAL EDUCATION (EXPLAIN) ☐

DO YOU HAVE ANY RECOMMENDATIONS REGARDING THE CARE OF THIS STUDENT WHILE ATTENDING THE UNIVERSITY?

YES ☐ NO ☐ IF YES, EXPLAIN FULLY

PHYSICIAN

NAME

SIGNATURE

PRINTED

ADDRESS

NUMBER STREET

CITY STATE

TELEPHONE NUMBER DATE

PHYSICIAN: Please mail completed form to:

UNIVERSITY OF WISCONSIN
DEPT. OF STUDENT HEALTH
1300 UNIVERSITY AVE.
MADISON, WISCONSIN 53706

IBM H90203

Fig. 1—Front side of new medical history and examination form.

UNIVERSITY OF WISCONSIN
DEPARTMENT OF STUDENT HEALTH

TO THE STUDENT: Please answer all questions. Consult your parents for accurate and complete answers to medical history questions. The information will be treated confidentially; it will not affect your college standing.

IMPORTANT

USE ORDINARY BLACK LEAD PENCIL (NOT INK OR BALL POINT PEN)
BE SURE TO MAKE YOUR MARKS HEAVY AND DARK
ERASE COMPLETELY ANY MARKS YOU WISH TO CHANGE

EXAMPLE — MARITAL STATUS: SINGLE | **MARRIED** | WIDOWED | DIVORCED | SEPARATED

NAME •

HOME ADDRESS •

•

BIRTH DATE

SEX: M F

AGE GROUPING: 16 OR UNDER | 17-21 | 22-30 | 31-40 | 41 OR OVER

MARITAL STATUS: SINGLE | MARRIED | WIDOWED | DIVORCED | SEPARATED

MOST OF YOUR LIFE

AREA OF RESIDENCE: U S & CAN | LATIN AMER | EUROPE | ASIA | OTHER

COMMUNITY SIZE (POPULATION IN THOUSANDS): FARM | UNDER 10 | 10-50 | 50-250 | OVER 250

RELIGION: CATHOLIC | JEWISH | PROTESTANT | OTHER | NO PREF

DO YOU HAVE A PERSONAL PHYSICIAN? YES NO

NUMBER OF TIMES YOU HAVE CONSULTED HIM IN THE LAST YEAR: NONE | 1 | 2 | 3 | MORE

IS HE IN THE MADISON AREA? YES NO

IS HE AN: MD | OSTEOPATH | CHIROPRACTOR | OTHER

IF M D, IS HE A: GENERAL PRACTITIONER | SPECIALIST | DON'T KNOW

IF SPECIALIST, WHAT FIELD? INTERNAL MEDICINE | PEDIATRICS | OTHER | DON'T KNOW

IF YOU BECOME ILL AT THE UNIVERSITY, DO YOU ANTICIPATE USING: STUDENT HEALTH SERVICE | PRIVATE PHYSICIAN

FAMILY

FATHER: LIVING | DECEASED — MOTHER: LIVING | DECEASED

CAUSE OF DEATH, IF KNOWN, AND AGE AT DEATH

NUMBER OF LIVING CHILDREN, WHO ARE YOUR FULL BROTHERS: 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 OR MORE

FULL SISTERS: 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 OR MORE

AMONG THESE, IS THERE A: TWIN PAIR | TRIPLET — ARE YOU A MEMBER OF A LIVING: TWIN PAIR | TRIPLET

AMONG YOUR LIVING FULL BROTHERS AND SISTERS, ARE YOU THE: OLDEST | 2nd | 3rd | 4th | 5th | 6th | 7th | 8th | 9th | 10th OR MORE

HISTORY

AMONG YOUR BLOOD RELATIVES, IS THERE ANY HISTORY OF, OR PRESENT ILLNESS IN, THE FOLLOWING?

	YES	NO		YES	NO
ALLERGY			CANCER		
HEART DISEASE			DIABETES		
TUBERCULOSIS			CONVULSIONS OR BLACKOUTS		
RECURRENT SEVERE HEADACHES			EMOTIONAL TROUBLES		
			OTHER SERIOUS ILLNESSES		

FOR EACH YES, SPECIFY ILLNESS AND RELATIONSHIP BELOW

UWH 627 IBM H90202

0	1	2	3	4	DO	5	6	7	8	9
0	1	2	3	4	NOT	5	6	7	8	9
0		2	3	4	WRITE	5	6	7	8	9
0		2	3	4	IN	5	6	7	8	9
0	1	2	3	4	THIS	5	6	7	8	9
0	1	2	3	4	SPACE	5	6	7	8	9

PERSONAL HISTORY

HAVE YOU EVER HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING?

	YES	NO		YES	NO
RHEUMATIC FEVER			DIABETES		
HEART DISEASE			CONVULSIONS OR BLACKOUTS		
TUBERCULOSIS			EMOTIONAL TROUBLES		
RECURRENT SEVERE HEADACHES			OTHER SERIOUS ILLNESS		

FOR EACH YES, EXPLAIN AND GIVE DATES

HAVE YOU EVER HAD THE FOLLOWING OPERATIONS OR INJURIES?

	YES	NO		YES	NO
APPENDECTOMY			HERNIA		
TONSILLECTOMY			FRACTURES		
OTHER SIGNIFICANT OPERATIONS OR ACCIDENTS (EXPLAIN BELOW)					

COMMENTS, DATES, ETC.

DO YOU HAVE THE FOLLOWING ALLERGIES?

	YES	NO		YES	NO
HAY FEVER			ASTHMA		
ECZEMA			HORSE SERUM		
PENICILLIN			OTHER DRUGS (NAME)		

HAVE YOU BEEN IMMUNIZED FOR THE FOLLOWING?

	YES	NO		YES	NO
TETANUS			SMALL POX (WITHIN LAST 5 YRS.)		
WHOOPING COUGH			POLIO (INJECTED)		
DIPHTHERIA			POLIO (ORAL)		

DO YOU HAVE ANY TROUBLE IN ANY OF THE FOLLOWING?

	YES	NO		YES	NO
HEAD, EYES, EARS, NOSE OR THROAT			KIDNEYS OR BLADDER		
CHEST			MUSCLES OR BONES		
HEART			MENSTRUAL DIFFICULTIES (WOMEN)		
STOMACH OR INTESTINES			OTHER TROUBLE		

FOR EACH YES, EXPLAIN

HAVE YOU EVER HAD X-RAY TREATMENT OR THERAPY? YES NO

IF YES, TO WHAT PART OF THE BODY? HEAD OR NECK | CHEST | OTHER

HOW MANY CIGARETTES PER DAY DO YOU SMOKE REGULARLY? NONE | LESS THAN 1/2 PACK | 1/2-1 PACK | 1-2 PACKS | MORE

TOTAL NUMBER OF YEARS YOU HAVE SMOKED CIGARETTES REGULARLY

Fig. 2—Back side of new medical history and examination form.

tions. All written notes should be made in this column because extraneous marks in the area of response positions may result in incorrect readings.

After the sheet has been processed by the Page Reader, it will become a permanent part of the students individual folder, always available for the Student Health physician to refer to when treating the student. The punched cards will make several efficient screening procedures possible.

The Student Health Department is responsible for assigning a classification to each student for participation in physical education classes and intramural sports. In the past, a staff physician read each form before assigning the classification. This was inefficient use of the physician's time because 90 per cent of the students need no restriction.

It will now be possible to select by machine this 90 per cent and to allow the physician to concentrate on the 10 per cent whose records need to be considered in detail before determining which sports and physical education activities are suitable for each individual. The home physician's written notes will be carefully reviewed.

The classifications for physical education must be completed before the start of the term. In the past, many medical forms arrived late in August or even after the start of classes. With 7,000 entering students and the prediction of doubled enrollment in 10 years, the problem is obvious. The community physicians can help by mailing the completed form directly to the Student Health Department promptly.

Other screening procedures will now be possible. Students who should be seen at the Student Health Department soon after their arrival on campus can be selected and offered an appointment. Those who could benefit from care in the Allergy Clinic, Headache Clinic, and the like, can be informed of these services. Students needing a particular immunization can be selected.

Statistics which will help in the administration of the Student Health Department can be quickly obtained. Lastly, the medical information on a population of students will be retreivable for valuable research studies.

TUBERCULOSIS INFORMATION AMONG MADISON ADULTS

IN APRIL AND MAY 1962, 53 volunteer workers for the Madison Tuberculosis Association distributed questionnaires on tuberculosis, as a personal and public health problem, to adults in the metropolitan Madison area. The survey was designed to aid the Association in planning public education programs for the control and eradication of tuberculosis. Specific objectives were to ascertain the extent of correct information most Madison adults possess in regard to tuberculosis, the prevalent fallacies and misconceptions surrounding the disease, attitudes toward tuberculosis and persons infected with it, and differences in attitudes and information levels of people in different socio-economic groups. The study was prompted, in part, by the suspicion that publicity about reduced tuberculosis death rates, new treatments for the disease, and the closing of some tuberculosis hospitals had fostered the evolution of some misconceptions which, if not identified and clarified, could seriously impede the control of tuberculosis.

The sample used in this research was selected so that every residential address listed in the 1960 Madison City Directory had an equal chance of being visited by a volunteer distributor. On contacting a sampling unit, the distributor followed a selection procedure whereby the single respondent from each residence was equally likely to be a male or a female. The 520 Madison adults who completed the questionnaires represent a response rate of 84 per cent of the original sample.

How knowledgeable are Madison adults on the subject of tuberculosis? Analysis of the data collected on their information levels indicates some strengths and weaknesses.

Kudos for Volunteers. First and foremost among the outcomes of this study is verification of the belief that volunteer workers can be effective in securing a high percentage of responses to a questionnaire about people's knowledge of and attitudes toward a given topic. In this project 53 volunteers from the Madison Tuberculosis Association received careful orientation and instruction, and then they obtained completed questionnaires from 520 (84%) households in a random sample of 618 residential addresses in metropolitan Madison.

Gains and Losses. The data collected by the volunteers reveal some important clues for the tuberculosis education program. It tells us that some old misconceptions about tuberculosis are subsiding. A vast majority of the adult respondents are aware that tuberculosis is not inherited. Few people want to maintain secrecy about a case of tuberculosis in their own families, and only a very small number are fearful of acquiring tuberculosis from an ex-

This research was conducted with an advisory committee of public health authorities, thoracic physicians, tuberculosis workers, and survey specialists. It was financed by the Madison Tuberculosis Association, and cosponsored by the Dane County Medical Society, the Dane County Public Health Department, and the Madison Department of Public Health. The data were collected and processed through the facilities of the University of Wisconsin Survey Research Laboratory and the Numerical Analysis Laboratory.

The complete survey report of this study is available from the Madison Tuberculosis Association, 115 West Main Street, Madison, Wis. 53703.

patient. But, though these misconceptions are fading, others are becoming more prevalent. Some that are apparent among the Madisonians are:

1. There are those who think that tuberculosis is practically wiped out, and very few individuals have correct information about the actual number of active cases of tuberculosis in the United States, or the number of new cases that are reported each year.
2. The fact that the largest number (not rate) of new cases are among middle-aged people is not known to many.
3. Whereas it is generally known that no age is safe from tuberculosis, few people realize that there is a relation between age and one's resistance to tuberculosis infection.
4. That the greatest number of tuberculosis patients come from the poorer walks of life is not well known.
5. Some folks have incorrect information about how children acquire tuberculosis.
6. Many people are aware of the purposes of the tuberculin test, but there are some who do not know the meaning of a positive or negative tuberculin reaction.
7. Few people can identify isoniazid as a useful antituberculosis drug.
8. There is lack of correct information about the length of hospitalization in the modern treatment of tuberculosis.
9. Some people are still under the impression that the extuberculosis patient is quite restricted in the type of work he can do safely.
10. Few people are aware of BCG vaccine.

Too, there is evidence in this study that without frequent reminders, people do forget and young people grow up without acquiring certain facts. In 1962 Madison adults have relatively low knowledge scores about:

1. Free care for tuberculosis patients,
2. Tuberculosis in animals,
3. Influence of pasteurization on tuberculosis germs in milk, and
4. Ability of tuberculosis germs to attack organs other than the lungs.

These are emphases in the education about tuberculosis for the 1930's and 1940's. They are less prominent in more recent years. To some extent they represent educational ground loss.

An Overview of Knowledgeability and Attitude. Fifty of the items in the questionnaire can be said to have a correct answer or a favorable response. For some of these questions, less than 10 per cent of Madisonians respond correctly or favorably. At the other extreme, for some questions, 90 per cent or more of the population give a correct or favorable response. Here is the distribution:

Per Cent Correct or Favorable Response	*Number of Questions*
1 to 20%	10
21 to 40%	2
41 to 60%	4
61 to 80%	12
81 to 100%	22
	50

On almost half of the questions of this type, better than 80 per cent of Madisonians score correct or favorable responses. That is a good record, but it leaves room for improvement through education. —WARREN H. SOUTHWORTH, DR. P. H., *Professor of Health Education*, University of Wisconsin, Madison.

Botulinum Antitoxin

THE STATE BOARD OF HEALTH has received word from the Communicable Disease Center (CDC) of the United States Public Health Service, that supplies of Botulinum antitoxin are available to physicians on an emergency basis.

Type E. Antitoxin is available from the Communicable Disease Center; Atlanta, Ga. Around-the-clock telephone coverage has been established at CDC. The telephone number is: Area Code 404–634–2561.

For Types A and B antitoxin, contact should be made with area representatives of Lederle Laboratory! For our area, they are:

J. W. Simons, Chicago, Ill., Telephone: CO 7–6400
P. J. Will, Minneapolis, Minn., Telephone: WE 5–1721

Around-the-clock telephone coverage is also provided by the above.

CDC pointed out that the 1963 outbreaks of Type E botulism, involving 22 cases, was an extraordinary occurrence and contrasts sharply with experience in the past 30 years. There is no expectation that the experience of 1963 will be repeated in the future. However, CDC did procure the emergency supply of polyvalent botulinus antitoxin, which includes Type E. The supply was imported from Denmark as it is not produced domestically.

The CDC announcement said that time does not permit laboratory studies prior to treatment to determine the botulism type involved. Thus it should be noted that Type E botulism has been associated with fish or fish products such as smoked fish, canned tuna, salmon eggs, etc. Types A and B botulism may be transmitted through a broad spectrum of improperly processed foods including fish and fish products. So, unless some form of fish is suspect as the vehicle, treatment with bivalent A and B antitoxin should provide optimum specific therapy. —DAVID JAMIESON, Wisconsin State Board of Health.

EW PRESIDENT

WILLIAM P. CURRAN, M. D.

The small community, family physician is personified in the newly installed president of the State Medical Society. He is Dr. William P. Curran of Antigo. With the exception of some 10 years, during which he obtained his medical education, Doctor Curran has lived in Antigo all his life which began on Sept. 24, 1903.

Doctor Curran attended St. John's parochial and Antigo high schools, and then entered Marquette University, Milwaukee, in the fall of 1922. He received his medical degree in 1930 from the Marquette University School of Medicine. His internship was served at St. Elizabeth's Hospital, Youngstown, O., from July 1929 to July 1930, and a residency at Johnston Emergency Hospital, Milwaukee, from July 1930 to July 1931. He returned to St. Elizabeth's Hospital for a surgical residency in July 1931 to July 1932. He then completed an internship and residency program at Bellevue Hospital, New York, N.Y., from January 1933 to July 1934.

Returning to his hometown, Doctor Curran began practicing medicine and surgery in September 1934. He immediately became a staff member of the Langlade County Memorial Hospital at Antigo and has retained that privilege to the present time. In 1938 Doctor Curran married the former Grace Brennan, and they are the parents of five children.

Doctor Curran became a member of the State Medical Society of Wisconsin in 1935. His sincere interest in organized medicine was recognized in 1954 when his colleagues elected him to the Council. He remained a councilor until 1963 when he was chosen president-elect. Doctor Curran's other associations include membership in the Langlade County Medical Society, American Medical Association, American College of Surgeons, Wisconsin Surgical Society, and the American Academy of General Practice.

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the WISCONSIN MEDICAL JOURNAL
Published Monthly

MAY 1964

Vol. 63 No. 5

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D. N. GOLDSTEIN, M. D., *Editorial Director*

Another Double Standard

■ AS THOUGH THE whole question of medical care costs weren't complex enough, the fiscal policy of hospitals adds a perplexing and irrational twist.

As everyone familiar with insurance matters knows, Wisconsin Blue Cross receives a 3% rebate from hospitals on the bills which Blue Cross pays. Thus, for every $100 the insured thinks the Blue Cross Plan is paying on his behalf, the plan is actually paying only $97.00. On that portion of his hospital bill which his insurance does not cover, the insured pays the full amount, without benefit of rebate.

The hospitals justify this peculiar practice by claiming that the 3% represents their saving in bookkeeping and collection costs as a result of dealing with the Blue Cross plans, which, presumably, pay promptly. Oddly enough, however, the hospitals do not offer this same 3% for prompt payment to all the patients who are not permitted to leave the hospital without settling their bills. Nor indeed do the hospitals offer the same discount for prompt payment to other insurance companies who offer hospitalization insurance.

A number of interesting questions suggest themselves in this connection. What special merit does Blue Cross money have for the hospitals that money originating from private insurance companies, and indeed, from private uninsured patients, doesn't have? In private enterprise the customary discounts for prompt payment of invoices is related to the rapid turn-over of capital investment on which ultimate profitability depends. In service businesses, in which category hospitals surely fall, the discount for cash or prompt payment is practically non-existent. Yet hospitals, while following the normal billing practices of service businesses, seem to find Blue Cross money so desirable that it gives it special inducement not available to its other income, which may be equally prompt.

If the hospitals themselves have determined that 3% of their costs can be reduced by prompt payment, what other reductions in costs can be obtained as a result of a study of their fiscal and administrative practices? Are the purchasing practices of the various departments of hospitals coordinated and efficiently administered? Are their accounting procedures in keeping with generally accepted auditing standards applicable to the peculiar circumstances of pro-

viding hospital care? Has any effort been made to trim the overhead cost of administration through the use of modern techniques of business management?

And, finally, by what moral standard do the hospitals give *one* of its customers a reduction in price that it doesn't give to all of its customers? A private business in interstate commerce caught in this kind of hanky-panky would soon find itself in trouble with the Federal Trade Commission, perhaps subject to prosecution. Are hospitals to be permitted a standard of morality lower than that which applies to the business community as a whole?

Hospitals may feel they have less to lose in a program of tax-supported health care than does the medical profession or the nation at large and therefore can afford to be indifferent to the necessity of maintaining a high standard of moral business conduct. If this is the case, pressure should be put on them by both the medical profession and private insurance companies to treat all of their customers alike: either give everybody the 3% discount for prompt payment or stop giving it to Blue Cross alone. Hopefully, the hospitals may see the light before Congress eliminates voluntary health care insurance altogether. —D.N.G.

Remembrances

THE CHARITABLE, Educational and Scientific Foundation of the State Medical Society of Wisconsin offers a new and more convenient means of making worthwhile memorial gifts. Booklets of detachable cards are being sent to Wisconsin doctors which, when used according to instructions, will enable them to contribute a gift in memory of a departed colleague or friend easily and effectively.

Upon receipt of the card and the accompanying check, the CES Foundation will mail a notification, according to the instruction of the donor, that a gift has been made in memory of the deceased, and it will also return a receipt to the donor acknowledging the contribution. To the credit of the CES Foundation, the "In Memoriam" notification and the acknowledgment have been tastefully designed and executed to reflect dignity and the importance of the occasion.

In recent years many groups as well as individuals have wisely converted the money that had previously been spent on flowers into a contribution to a worthy cause. In this way a gaudy, transient, and frequently meaningless gesture that sometimes did violence to the religious sensibilities of the sorrowing family was transformed into a significant expression of appreciation for the humanity of the deceased. A memorial gift to a fine charity is a tribute that speaks of high regard; it is a good work more beautiful than flowers, more permanent than bronze. For an act of philanthropy fades not, but multiplies and magnifies in the on-going life of our society.

The State Medical Society at the present time makes a memorial donation to the CES Foundation upon the death of a member physician, and so do some of the county medical societies. Many clinics and not a few individual doctors contribute gifts of money in memory of their colleagues, relatives, and friends. The practice is growing among business firms and nonmedical persons as well. The ease with which gifts can now be made to the CES Foundation should encourage such donations, especially since the beauty and the decorum of the "In Memoriam" notifications make the gifts particularly appropriate.

As a worthy cause, the CES Foundation can hardly be surpassed as a philanthropy for doctors and for those for whom health care is a matter of vital concern. Its funds are directed toward the promotion of professional education and student loans; public education in medical matters; research in science and economic problems, often with the collaboration of other agencies and organizations; and charitable efforts, including very real assistance to physicians who have suffered adversely. Donors to the CES Foundation may earmark their gifts for specific purposes, or they may permit the Trustees to use the funds for any purpose for which the Foundation was created. While the donor is identified in the "In Memoriam" notification, the amount of the gift is never revealed; and the gift can be claimed as a tax deduction.

When the booklet of contribution cards is received, it should be retained until the occasion for use arises. Then the cards should be used generously. The idea is good—convenient, time-saving, thoughtful, and appreciated by those to whom condolences are sent. —D.N.G.

Sword and Buckler: Part II

Reprinted with permission from the NEW YORK STATE JOURNAL OF MEDICINE, February 1, 1964

■ OTHER THAN through "tip-offs" only the insurance companies themselves can detect cheating on the part of beneficiaries. Maintaining a thorough utilization program is a difficult and expensive proposition. UMS (United Medical Service), the Blue Shield Plan, has a program that *Medical Economics* (May 21, 1962) described as "what may be the country's most efficient system for detecting overutilization and abuse of Blue Shield." In fact, several other plans are exploring aspects of the UMS program for their own use, and the National Association of Blue Shield Plans recently sent a team to New York City for a week to study UMS detection procedures with a view toward recommending them to other plans. But these facts do not mean that the program is perfect. Reaching perfection is simply a matter of determining what it is worth, that is, how much of the subscribers' money the plan is willing to pour into the job of catching the cheaters.

For example, every claim examiner hired by UMS must have some medical background, either medical school attendance, nursing training and experience, military service in the Medical Corps, or the like, and must pass an examination designed to measure his medical knowledge. Moreover, each examiner is put through an intensive training program of which the first phase alone lasts three months and includes a review of basic anatomy as well as training in the procedural aspects of reviewing claims. The examiners are backed up by a staff of physicians who act as final reviewers of all complicated cases.

This sounds like a good program, but certainly UMS could do a better job if it hired only physicians as claim examiners and used them in conjunction with a team of attorneys. But would the funds saved as a result of this added safeguard justify the expenditure of subscribers' money for these high skills?

To help in detecting excessive utilization, examiners are organized according to geographic areas so that each will become familiar with the patterns of practice in his area and thus be better able to spot any unusual practice or trend. But without increasing the staff at the subscribers' expense, how much attention can be paid to spotting unusual practices when there are 8,000 claims a day to be processed?

Through the wonders of a massive electronic data processing system, any claim that is not fully consistent with the contract under which it is submitted or that has discrepancies such as conflicting dates within it is "thrown out" by the computer and subsequently reviewed by an experienced claim examiner on a second time around. Some 1,500 cases a day receive this second review, but even this cannot catch someone who has taken great care in submitting a fraudulent claim.

To try to detect these cases, UMS does such things as spot-checking claims on a regular basis through inquiries to subscribers and hospitals, matching up information gained from these sources with physicians' reports even when the report itself offers no grounds for suspicion. Actually, fewer than 200 cases a day are checked in this manner, but to investigate many more would be not only a costly proposition but also an insult to the great majority of physicians, who never report anything but the absolute truth.

As a further check, UMS mails check copies to physicians and subscribers, permitting both to audit the UMS payment in relation to services rendered; analyzes monthly, quarterly, and annual "procedure runs" to detect changes in the utilization of certain procedures and to correlate them with certain practitioners or classes of practitioners (this analysis also helps in determining critical areas that require further study and in perceiving trends in medical practice); analyzes quarterly listings of physicians' earnings from UMS, looking for sudden increases in earnings or exceptionally high annual payments and analyzing individual physicians' procedure runs in these cases; analyzes procedure runs for every physician for whom a pattern of practice or method of reporting indicates need for further investigation; employs field investigators to interview subscribers who have lodged complaints against their physician or who have been treated by a physician under investigation by UMS.

Detecting evidence of abuse, however, is only part of it. The teeth in any such program must lie in eliminating the abuse, both by removing the perpetrator from the opportunity for further abuse and by providing penalties sufficient to deter others from similar actions.

It has been said UMS is often overly reluctant to take action against physicians who have abused its program of benefits. Perhaps this is because of a feeling that it needs the cooperation of physicians if its program is to succeed. Perhaps it is out of respect for the medical profession and confidence in the profession's ability to take care of its own problems. Or perhaps it is because organized medicine itself has seemed at times to be a sort of protective society for its own members. Or perhaps it is a little of each. At any rate, UMS usually prefers to tell a physician that his practices are out of line and to give him every chance to mend his ways before going any further. And in enforcing its utilization program it relies heavily on the cooperation of physicians themselves. Fortunately, both individually and through their county medical societies, they have been displaying an increasing willingness to help rid their profession of the few abusers whose actions have tended to cast a shadow on the entire profession.

The primary review of cases involving possible abuse is made by physicians themselves through the Physicians Review Committee, a group composed of two representatives appointed by each of the 17 county medical societies in the UMS area and representing each of the specialties as well as general practice. When further action is warranted, several courses are open to UMS. A case may be referred to the appropriate county medical society, which may reprimand, censure, or suspend a physician or even recommend that the matter be referred to the Board of Regents of the Division of Professional Conduct of the State Education Department. UMS also may refer the case to the district attorney although in the past it has been reluctant to so involve physicians. In fact, despite its elaborate detection procedure and apparent success in uncovering abuses, UMS has referred only 2 cases to the district attorney and sends only about 12 a year to the Board of Regents. UMS also seeks refunds, where warranted, and may abrogate a participating physician's agreement with the plan.

Other evidence of increasing cooperation on the part of organized medicine is apparent in the establishment in some county medical societies of utilization committees that have been encouraged by UMS. By operating in a manner similar to hospital tissue committees, these groups can themselves participate in the prevention of excessive utilization problems.

But despite a system that makes it hazardous to run the risk of fraud or abuse; despite the increasing realization by the county medical societies of their responsibility in reducing abuse and overutilization of health insurance benefits and their increasing tendency to crack down on offenders; despite a continuing education program, not only on the part of UMS but of most Blue Shield and other voluntary health insurance organizations, to make both physicians and public more cognizant of the financial damage of overutilization; despite the consequences of medical society suspension or grand jury action and subsequent conviction—the answer to stopping abuses of health insurance benefits lies only with the personal determination of the individual physician. Perhaps we will never wipe out greed or dishonesty or our deepseated emotional motivations, but we can at least appeal to reason.

Only when the physician becomes aware that it is not an industrial tycoon or a mass of wealthy stockholders whom he is hurting but every Blue Shield subscriber today and the millions more who may become Blue Shield subscribers in the future can we hope to solve the problem of overutilization.

Only when he remembers that Blue Shield was created by the medical profession to solve pressing economic problems relating to medicine and that the continued solution of these problems depends on a strong Blue Shield will overutilization be stopped.

Only when he realizes that ultimately it is not in the best interests of his patients when he submits to their pressure for "abuse" favors will excessive claims be reduced.

Only when he realizes that because of the serious consequences involved for the medical profession and the American people, the plans must be policed—and that if the polic-

ing isn't done by the local plan and its cooperating physicians, it will be done by official agencies—will the problem be solved.

The damage that has been done to the public image of the physician during recent years is evident. But it is nothing compared to what could happen if zealous public officials feel they must cite statistics of cheating and seek the power to control our profession in areas where we have always prided ourselves on our desire and ability to police ourselves.

We help to protect our own profession and our own professional freedom when we protect our colleagues from unjustified public scrutiny or abuse. But when we offer this protection where scrutiny or criticism is in fact warranted, we do not act in our best interests. If we fail to do our full part in eliminating abuse of health insurance benefits, the abuses are bound to increase, and we will lose even the right to do our part.

Not only should we seek to strengthen our own societies' means for eliminating abuse, and not only should we seek to establish committees for this purpose in every society to prevent abuse, but every physician must serve as his committee of one to insure that no abuse stems from his own practice.

ANALGESIA IN HEMOPHILIA . . .

BY ARMAND J. QUICK, M. D., MILWAUKEE

WHILE THE ultimate solution of hemophilia is expected to come from the astute contemplations of pure scientists in ivory towers, the great need, meanwhile, is for more sons of Martha to grapple with the mundane problems of this disease.

Those who see hemophilia at the bedside are aware of the erroneous concepts that are still widely held. The hemophiliac does not have uncontrolled bleeding from mere scratches. External bleeding, in fact, is fairly uncommon and few ever die from exsanguination. It is pain—excruciating pain—that most often prompts the call for medical help.

Pain is more common in the two forms of hemophilia (A and B) than in the other bleeding diseases. The probable reason is that the bleeding is deeper and therefore is more apt to cause pressure on sensory nerves. The first step obviously is prophylactic, namely, to abort the hemorrhage. It is surprising how often the simple application of cold and pressure immediately after a contusion brings this about. Cold constricts a blood vessel and since contraction is one of the first steps in the hemostatic chain of events, the beneficial effect can readily be understood. Yet, even today, one still finds occasionally that the hemophiliac is advised to use hot applications. This has done, and continues to do, immeasurable harm as well as accentuate the problem of pain.

It may seem surprising that one of the best analgesic agents in hemophilia is fresh or frozen plasma. It has been repeatedly observed that the continuous pain from hemorrhage is greatly alleviated or mitigated by a transfusion of this agent. Sometimes several hours are required before the effect is manifested. In one instance a patient, with severe hemophilia B, for a week had continuous pain in his elbow from a hemarthrosis, obtained sudden and almost complete relief exactly fifteen hours after a 500 ml. of fresh frozen plasma. Often, the severe pain disappears during or shortly after the transfusion.

Curiously, a patient with bleeding into his leg experiences the greatest comfort by having his leg hanging down and finds elevation of his limb intolerable. On one occasion it was observed that a boy with such a hemorrhage, who would not permit his leg to be changed from the pendant position, unconsciously pulled his leg up on the bed nearing the completion of the plasma transfusion. These are clinical observations for which no satisfactory explanation can be offered.

It should be stressed that not all pain is controlled by a fresh frozen plasma transfusion and that analgesic drugs must be given. Unfortunately, this often creates new problems because the pain in the joints following repeated hemarthroses may be arthritic in type. Aspirin is frequently found to be effective and the combination of aspirin and codeine is especially efficacious. Aspirin, however, is not an innocuous drug and evidence is accumulating to suggest that it can by itself induce bleeding. No adequately controlled study of this untoward action of aspirin has been made and, therefore, the question of whether it accentuates the bleeding in hemophilia remains unanswered. It seems justifiable, nevertheless, to give the drug when it effectively alleviates the pain. But the indiscriminate and uncontrolled use of aspirin should be discouraged.

The most serious problem arising from the use of analgesics in hemophiliacs is addiction. Morphine is the most effective drug in allaying the exquisite pain so common in this disease and, occasionally, one is justified to give this agent. It should, however, be given with great caution because addiction is especially prone to develop in patients with chronic and recurring pain. Since other drugs such as meperidine hydrochloride (Demerol) are available, the opiates are used much less than formerly in hemophilia. Unfortunately, the newer analgesic drugs also produce habituation and therefore demand vigilance on the part of the physician.

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the wisconsin medical journal

VOLUME 63/NUMBER 6 JUNE 1964

President's Message to the House of Delegates

By W. P. CURRAN, M. D., Antigo, Wisconsin

■ ONE YEAR AGO I appeared before this august body of the State Medical Society, as your president-elect, and on that occasion I mentioned the fact that I would have one year of apprenticeship, under a learned and worthy president, to acclimate myself with the workings of the State Society. It is surprising how rapidly that year has passed, and how much educational matter, both in printed communication, and personal contacts has been presented to me.

It is the duty of the incoming president of this Society to address the House of Delegates at the Annual Meeting and to inform them of any objectives that may seem to be important to him to try to attain in the year of his presidency. It is my hope that in the coming year greater unity can be achieved in the workings of our Society; and I propose to spend this short time with you in a discussion of unity, its importance to our Society, and suggested methods of attaining this unity, and what it can do for the physicians of Wisconsin. If, during this presentation, I appear to be dogmatic it is purely a coincidence; but I wish to speak frankly on this matter which is close to my heart, and I believe, very important to all of us.

To have any kind of progress there must be a difference of opinion on all matters brought before any group, for without it a thorough understanding of the problem cannot be reached. However, this difference of opinion must be an honest and enlightened one, and all conclusions must be based on true facts, not on misinformation or a biased judgment.

To have all the facts before one is a must, and this brings to mind the amount of participation of the membership of this Society, in matters both of a legislative and a scientific nature. This will, I believe, be substantiated by the following observation. During this past year, it has been my privilege to attend a few of the meetings of the county societies and also numerous meetings of various committees of our State Society. I have been impressed by the keen interest and sound judgment of the physicians involved in

Presented before the House of Delegates at the 123rd annual meeting of the State Medical Society, May 10, 1964, Milwaukee.

these activities and their willingness to serve in this type of work, with no thought of recompense to themselves, and only the betterment of medicine in this state and the nation, as their final goal. This is very reassuring to one who, the Lord willing, will assume the presidency of this Society, in a matter of a few short hours. However, the disturbing factor in this picture is the relatively few physicians who will take the time from their busy practice to engage in this very important aspect of organized medicine. If you review the names of the physicians listed as members of the various committees of our Society, you will be reading the roll of busy practitioners in our state. There is an untapped source of brilliancy present in our membership, and it should not be left to mold and decay because of inactivity. I strongly urge greater participation of the entire membership in all activities of our Society, both at the county and state level.

Communication is a vital part of unity in any society, and this is especially true in our State Medical Society. A membership that is not well informed on all matters concerning it cannot make adequate judgments, and this leads to misunderstandings which are a major cause of disunity. At the present time there is no shortage of printed information from our staff at the State Society office, but the big problem in this area is to have the members read this material which is submitted to them.

We all know how flooded our mail is, with the various scientific journals, and the tons of material presented to us by the paramedical groups, but I urge you to open and read the material mailed you from our State Society office. You will then have some inkling as to what is on the fire concerning medicine in our state, and help you in making a sound and informed conclusion in these matters. I cannot emphasize enough the importance of personal contact in the area of communication, and it is here that the councilors of our State Society play a vital part. I know that there are areas in our state where it is a tremendous task to keep in close contact with the county societies in the councilor districts, but this must be done if effective liaison is to be maintained between the State Society office and the membership. There is a minimum of four Council meetings a year, and I would suggest that an attempt be made by the various physicians who are members of the Council to, if possible, contact their membership after these meetings, and keep them informed on the facts of life.

It is also important that you physicians here, as delegates to the State Medical Society, make a detailed report to your home Society at the conclusion of the activities of this House.

I know that the fulfillment of these requests will take a great deal of your time and effort, and you may think that this is something for "George," or even "Charlie," to do, but the fact is, that in these matters you are the "Georges" and the "Charlies" who will have to do the work, if it is to be done.

To accomplish these suggestions during the coming year, I will need your help, both as individual physicians and the State Medical Society as a whole. We all need the help of one another. I know that I will have the untiring effort and full support of our secretary, Mr. Crownhart, and his staff. Let us both do all we can to abolish misunderstanding, which is the greatest cause of disunity. If we can achieve unity in our State Society, the limits of progress which we can encompass are limited only by our activity and ambition. It will provide us with an efficient working group which is so necessary to preserve ourselves in our way of life. It will add luster and comfort to the atmosphere in which those who will follow us in medicine in Wisconsin in the years to come will have to live and practice.

I would be remiss in my duty as president-elect of this Society if I did not at this time commend to you the work of our retiring president, Dr. Bill Egan. He has been untiring in his efforts to make the State Medical Society of Wisconsin one of the best in the nation. He has spent countless hours in committee meetings and has forsaken the comfort and joy of his home and family to bring the message of organized medicine to one and all in our state. He has been a stern teacher of mine during the past year, and for your information, was the same type of man when I was fortunate to have had him as a teacher in my medical school days. He has been stern, yes, but understanding and honest in all of my dealings with him. Many thanks to you, Dr. Bill Egan, and may the satisfaction of a job well done be my salute to you.

Primary Hyperthyroidism—Report of a Case of Recurrence Eight Years after Successful Surgery

By D. JOE FREEMAN, M. D., Wausau, Wisconsin

■ OSTEITIS FIBROSA generalisata of 38 years duration is unusual. Recurrent primary hyperparathyroidism is rare. In patients with hyperparathyroidism without chronic renal disease the decision to perform parathyroidectomy for an adenoma is not difficult to make. Should an adenoma occur in the presence of chronic renal disease, this decision is often reached with hesitancy and trepidation. The following case demonstrates all of these unusual features. Two parathyroidectomies were performed at an interval of eight years.

Case Report. A 57-year-old white woman was first seen in July 1953 with the chief complaint of swelling and pain in her left leg of four months duration. Her illness began in 1925 at which time multiple "osteomas" of the right upper and lower jaws were removed. Similar procedures were subsequently repeated five times during the next several years. About 1935 she began to complain of stomach pain and occasional nausea. During a hospitalization in October 1948 she was described as undernourished and had dry, scaling skin "with some brownish spots." The alveolar ridge on the right was abnormally wide and a "hypertrophic tumor" was noted posteriorly in the left, lower jaw. A complete blood cell count, urinalysis, chest x-ray film, cholecystogram, and gastrointestinal series were normal. The patient was believed to have a functional gastrointestinal disorder and discharged.

Four years later, in 1952, she began to develop painful swellings in the left tibial and distal ulnar areas. When seen in July 1953, she also reported polyuria, weakness, and chronic constipation, and claimed anorexia associated with a 25 lb. weight loss in the past year. The physical examination demonstrated a moderately emaciated, dehydrated, and crippled white woman with scattered café-au-lait lesions, surgical deformities of the right mandible, tender hard swellings of the left tibia (proximally and distally) and distal ulna, a small tumor of the posterior alveolar ridge of the left mandible, and a "hickory nut"-sized firm nodule in the inferior pole of the left thyroid lobe.

First Parathyroidectomy. The patient was hospitalized. Routine laboratory data were not remarkable. The results of the chemical tests are summarized in Table 1. A bony survey of the left tibia, left forearm, chest, hand, skull, and jaws demonstrated generalized demineralization and multiple cystic lesions most prominent in the left mandible, tibia, hand, and ulna. Essentially pathognomonic subperiosteal cortical bone resorption of the phalanges was present (Fig. 1). A diagnosis of primary hyperparathyroidism, parathyroid adenoma, and osteitis fibrosa generalisata was made and the patient was referred to another clinic for parathyroidectomy. This clinic's laboratory findings are listed in Table 1. Small renal calculi were present bilaterally. Two parathyroid adenomas were removed, one weighing 8.7 Gm. and the other 2.6 Gm. The cervical region was explored and no other abnormalities were found. She was last seen at this clinic in February 1954. At that time, she was taking 400,000 units of vitamin D and 24 teaspoonfuls of calcium lactate daily. Clinically, she was quite well. The salient blood studies are summarized in Table 1. The vitamin D therapy was discontinued and her calcium lactate was reduced to 10 teaspoonsful per day.

In the next few years the patient did quite well. In 1958 and 1959 she began to develop symptoms of recurrent epigastric, right upper quadrant and right flank pains which were occasionally associated with nausea and emesis. In April 1959 a cholecystectomy was performed elsewhere for chronic cholecysti-

tis and cholelithiasis, but her symptoms continued. In May 1961 she noted a lump in her neck on the left side and consulted another physician. The chemical data at this time are noted in Table 1. She was seen in our office in September, 1961 with continuing symptoms and was hospitalized. More recent complaints included anorexia, constipation, weakness, polyuria, and dizziness. The physical examination demonstrated an asthenic white woman with a 3 to 4 cm. nodule in the inferior pole of the left thyroid, slight tenderness on percussion of the lower dorsal and lumbar spines, dorsal kyphosis, and nodular swelling of the proximal and distal left tibia.

Admission laboratory data demonstrated no unusual changes in the hemogram or urinalysis. A 2+ albuminuria was present on one occasion. Two urine cultures produced a mixed flora of *Escherichia coli* and alpha hemolytic streptococci. The *E. coli* organism was sensitive to nitrofurantoin (Furadantin). The fasting blood sugar level was 119 mg. per 100 ml.; serum sodium 130, potassium 4.7, chloride 110, and carbon dioxide 26.8 mEq./l. Other blood chemistry studies are summarized in Table 1. Chest x-ray films were considered comparable to those in 1953 and 1959. As before, skeletal demineralization, calcific aortic atherosclerosis, and suggestive early cardiac enlargement were apparent. An electrocardiogram was consistent with left ventricular hypertrophy and strain. X-ray films of the lumbar spine revealed moderate, generalized demineralization and slight biconcavity of the vertebral bodies. No cystic areas were seen. It was believed that these changes were compatible with either postmenopausal demineralization or hyperparathyroidism, or both.

Second Parathyroidectomy. A high liquid intake was maintained and nitrofurantoin was given in doses of 100 mg. four times a day for nine days. Under local anesthesia, a neck exploration was performed in October 1961. The entire left lobe of the thyroid was removed along with a parathyroid adenoma of the chief cell type (Fig. 3). No other lesions were found. The preoperative and postoperative blood chemistry studies are noted in Table 1.

The first week of her postoperative course was relatively uneventful; but the second, third, and fourth weeks witnessed the development of increasing hypoparathyroidism. Her serum electrolyte studies were repeated 16 days postoperatively, and the serum sodium level was then 140 mEq./l. Potassium, chloride, and carbon dioxide levels were essentially unchanged. Calcium gluconate was administered intravenously on an intermittent basis for several weeks, and she was discharged after the fourth week on a daily regimen of four capsules of dihydrotachysterol (Hytakerol); 400,000 units of vitamin D (calciferol); 8 Gm. of calcium lactate; and a high calcium, low phosphorous

TABLE 1—*Blood Chemistries*

Date	Calcium (mg. 100 ml.)	Phosphorus (mg. 100 ml.)	Alkaline Phosphatase (King Armstrong)	Urea (mg. 100 ml.)	Creatinine (mg. 100 ml.)	Albumin/globulin (Gm. 100 ml.)
Normal values	9-11	2.5-4.0	4-10	10-15	1-2	3-6/1.5-3
July, 1953	18.4	2.9	13			
Aug., 1953	18.8	4.2	61	64		
Aug. 20, 1953	(OPERATION 1)					
Feb., 1954	9.1	3.6				
May, 1961	13.2	3.8	8.0	33	2.5	
Sept., 1961	16.2	6.7	17.7	71	4.5	3.4/3.7
Oct. 4, 1961	(OPERATION 2)					
Pod* 1	10.0	4.8		76		
Pod 8	6.3	3.5	19.8	45		
Pod 16	6.0	2.7	30.9	31		
Pod 22	4.5	6.3	18.9	40		
Pod 26†	5.2	5.4	22.3	43		
Nov., 1961	6.8			35		
Dec., 1961	6.7	4.7	9.5	35		
Jan., 1962	7.4					
June, 1962	7.4	4.2		35		
May 7, 1963	5.0	7.6	3.8	86	6.9	4.8/2.4
May, 27, 1963	9.6			39	3.9	
Aug. 20, 1963	10.0			46		

*Postoperative day.
†Oct. 30, 1961.

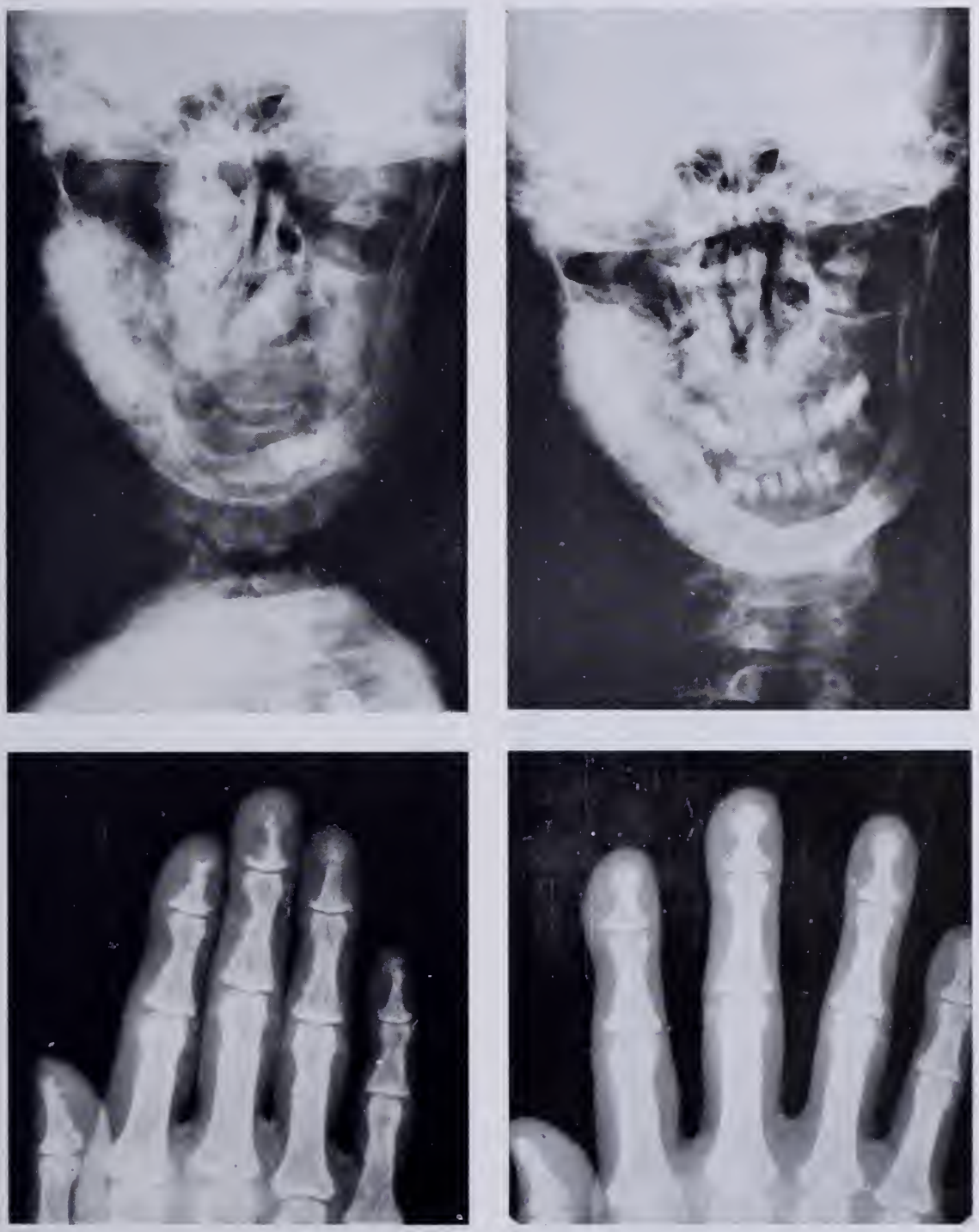

Fig. 1—Comparative films of the mandible and right hand taken in 1953 (left) and 1963 (right) demonstrate the initial marked skeletal demineralization and multiple "cysts." Striking is the essentially pathognomonic subperiosteal resorption of the cortical bone in the phalanges. The persistent hyperostotic changes in the mandible are undoubtedly residuals of the multiple bone curettements (and complicating osteomyelitis) done in the late 1920s.

Fig. 2—Comparative films of the left tibia taken in 1953 (left) and 1963 (right). Note the large cortical cysts present in the proximal and distal tibia.

diet. Following discharge her condition progressively improved, and by January 1962 she felt clinically well and demonstrated no signs of neuromuscular irritability on a daily regimen of 100,000 units of vitamin D and 2 Gm. of calcium lactate in divided doses. In June 1962 she continued her satisfactory clinical state. Her blood pressure was 180/90 mm. Hg. The chemical studies performed are summarized in Table 1.

Nineteen Months Follow-up. In May 1963 she again presented herself with complaints of anorexia, nausea, vomiting, and midepigastric pains of about one week's duration. Hematemesis and melena were denied. In the interval she had discontinued all of her medications except the 2 Gm. of calcium lactate taken daily in divided doses. She reported that all winter she had felt weak and jittery with occasional aching in her legs and frequent colds which were often associated with epistaxis.

The physical examination was essentially comparable to those previously done except that mild pallor, twitching of the eyelids, an uncontrolled atrial fibrillation (average ventricular rate 130), and mild epigastric tenderness were evident. Her blood pressure was 170/110 mm. Hg. Chvostek's sign and Trousseau's test were negative. Hospitalization again was advised.

Laboratory data on admission demonstrated a hemoglobin level of 9.2 Gm. per 100 ml., hematocrit 29%, serum glutamic oxalacetic transaminase 20 units, serum amylase 90 units, white blood cell count 10,700 per cu. mm., and cholesterol level 277 mg. per 100 ml. The urinalysis indicated a specific gravity of 1.013, pH, 3+ albumin; and a sediment containing 30 to 50 white blood cells, 2 to 3 red blood cells, and no casts. The chemical studies indicating hypoparathyroidism are summarized in Table 1.

On a daily high liquid intake of 200,000 units of vitamin D, 8 Gm. of calcium lactate, 45 Gm. of an aluminum hydroxide preparation (Aludrox), and a high calcium-low phosphorous diet she progressively improved. A normal sinus rhythm spontaneously returned the day after admission. A chest x-ray film, flat plate of the abdomen, and a gastrointestinal series were not contributory. For the record bone x-ray studies were obtained (Figs. 1 and 2). Reserpine therapy of 0.25 mg. at bedtime was also started, and she was discharged.

She failed to return for a follow-up examination until August 1963. In the interval she had discontinued all of her medications except the 2 Gm. of calcium lactate taken three times a day, and she felt "fine." She again had an uncontrolled atrial fibrillation (apical rate 140), but no obvious cardiac failure. Her blood pressure was 190/110 mm. Hg. Digitalization was undertaken. The serum calcium level was 10.0, and blood urea nitrogen 46 mg. per 100 ml. Final requirements for vitamin D, calcium, and antihypertensive agents remain to be determined.

Discussion. Excellent discussions of hypercalcemic states,[1, 2] primary hyperparathyroidism,[3–9] hypoparathyroidism,[10–12] and renal osteodystrophies[12–14] are recently available and will not be detailed. One of the reasons for reporting this patient's illness is to illustrate the differential diagnosis of primary versus secondary hyperparathyroidism. The serum calcium level is of funda-

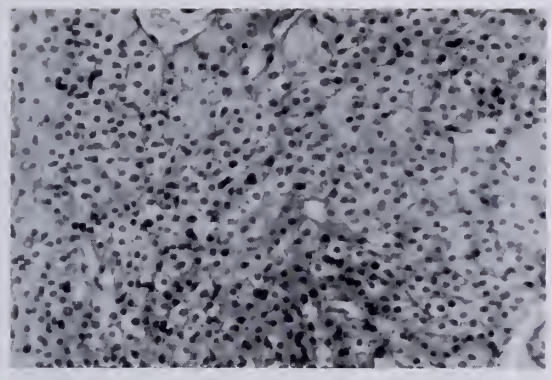

Fig. 3—Low-power photomicrograph of the chief cell adenoma removed in October, 1961.

mental importance. It is normal or low in the latter circumstance,* while its elevation above normal points to primary hyperparathyroidism. If a nodule is also present in the thyroid gland, primary hyperparathyroidism is practically a certainty. The hyperparathyroidism secondary to chronic renal disease is characterized by hyperplasia, not adenoma formation. Since subtotal parathyroidectomy in azotemic renal osteodystrophy is now being recommended in selected cases,[13] the question of whether one is dealing with primary or secondary disease may soon be muted by the surgeon's knife. In the absence of osteodystrophy, however, the decision is of paramount importance.

The problem of managing the present patient's hypoparathyroidism was demanding. At present supplemental calcium alone seems satisfactory. The normal serum electrolytes mitigate against chronic renal acidosis being a significant factor in this requirement. Since the effects of vitamin D may last for months following discontinuation,[10] it may well be that this agent will be intermittently indicated in the future.

The final reason for reporting this case is to record another rare example of recurrent primary hyperparathyroidism due to a new parathyroid adenoma. Watanabe, Baxter, and Beck[15] report seven such cases from the literature and add two of their own. Only one of these nine cases had renal disease comparable to the patient reported here. Pearl, Sternberg, and Dingman[16] reported recurrent hyperparathyroidism in a 45-year-old Negro woman. However, this occurred in a single adenoma which regenerated to produce recurrent disease after initial infarction during neck exploration; it was not due to a new adenoma.

* There is some dispute about this point, but the current opinion is that it is valid.[1, 12, 14]

Summary. A rare example of recurrent primary hyperparathyroidism is reported. The spectrum of this patient's illness included severe osteitis fibrosa generalisata of 38 years duration, a new adenoma 8 years after her initial parathyroidectomy, hypoparathyroidism following her second parathyroidectomy, and significant azotemic renal disease. The often challenging differential diagnostic problem between primary versus secondary hyperparathyroidism is illustrated.

Wausau Clinic.

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Duodenal Obstruction with Mongolism

By RODERICK E. DARBY, M. D.
and ABRAHAM MELAMED, M. D.

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■ MONGOLISM is present in 22 to 31 per cent of all cases of congenital duodenal atresia or stenosis.[1-3] The association of mongolism and duodenal atresia or stenosis has not been widely recognized. This report describes two cases of intrinsic congenital duodenal obstruction with mongolism.

Report of Cases. *Case 1.* A 6-month-old white female infant was hospitalized with a 2-day history of abdominal distention and vomiting. Emesis occurred shortly after each feeding. The bowel movements were regular with stools being of normal color and consistency. There were several previous bouts of vomiting during the 2 months prior to admission. The infant was born prematurely, weighing 3 lb. and 3 oz. Labor and delivery were uneventful. The patient was recognized as a mongoloid soon after birth. Previous obstetrical history of the 26-year-old mother included one delivery of a normal-term female infant and another pregnancy which aborted during the fifth month of gestation.

Physical examination revealed a poorly developed, dehydrated, mildly cyanotic female infant weighing 9 lb. and 12 oz. A mongoloid facies consisting of prominent medial epicanthal folds and a protruding tongue was evident. The cranial sutures were widely separated and the anterior fontanel was large. A grade 2 systolic murmur was heard over the precordium. The abdomen was soft but moderately distended and tympanitic to percussion. Hypermobility of all joints was present as well as a widened space between the great and second toes. Examination of the hands disclosed single transverse palmar creases and bilaterally shortened, incurved fifth fingers.

A roentgenogram (Fig. 1) of the abdomen revealed marked gaseous distention of the stomach and the proximal portion of the duodenum. A scattered gas pattern was noted in the small and large intestine. Barium contrast studies of the upper gastrointestinal tract (Figs. 2 a and b) confirmed the presence of a dilated stomach and proximal segment of the duodenum. Narrowing distal to the dilatation was not clearly demonstrated. The contrast medium passed into the jejunum.

Radiographic examination of the pelvis indicated an iliac index of 55, characteristic of mongolism. Roentgenograms of the hands revealed hypoplasia of the middle phalanges of the fifth fingers.

On the fifth hospital day, an exploratory laparotomy revealed the presence of dilatation of the stomach and duodenum proximal

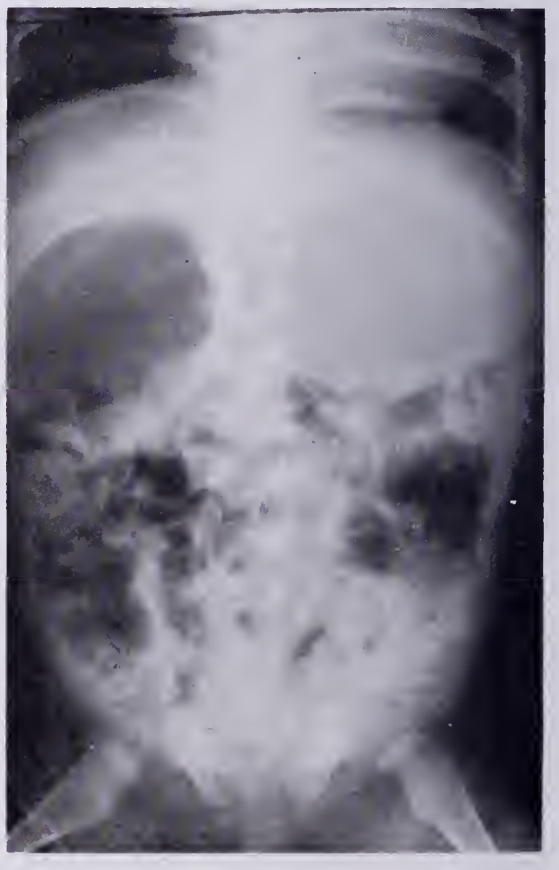

Fig. 1—Case 1. Distended stomach is seen in the left upper quadrant of the abdomen; markedly distended first and proximal descending portions of the duodenum in the right upper quadrant.

From the Department of Radiology, Evangelical Deaconess Hospital.

to a stenosis. Duodenojejunostomy was performed. The patient died on the third postoperative day. Autopsy confirmed the findings of a mongoloid infant with congenital duodenal stenosis located 8 cm. distal to the pylorus with dilatation and hypertrophy of the stomach and the proximal portion of the duodenum. Congenital heart lesions consisting of a ventricular septal defect of the atrioventricular commune type and a patent ductus arteriosus were also present.

Case 2. Shortly after birth, this premature white female twin vomited following each feeding. Emesis was projectile on several occasions and the vomitus consisted of recently ingested formula. Several small meconium stools were passed. Except for the early onset of the labor, the pregnancy and delivery were unremarkable. A single placenta was delivered but whether one or two chorions were present was not noted. The 43-year-old mother had had seven previous pregnancies, all resulting in normal, viable, term infants.

Physical examination disclosed a poorly developed female infant weighing 3 lb. and 15 oz. at birth. Prominent medial epicanthal folds, a small nasion, and an enlarged tongue provided a mongoloid appearance to the infant. The abdomen was soft and not distended. Hypermobility of all joints and generalized poor muscle tonicity were present. The fifth fingers were bilaterally incurved and shortened.

A plain roentgenogram (Fig. 3) of the abdomen demonstrated gaseous distention of the stomach and the proximal portion of the duodenum. No other gas shadows were present within the abdomen. Upper gastrointestinal examination (Figs. 4 a and b), employing a 40 per cent diatrizoate sodium (Hypaque) formula, revealed dilatation of the stomach and the first part of the duodenum. There was no passage of the opaque medium into the descending duodenum.

Roentgenograms of the pelvis demonstrated an iliac index of 78—within normal limits. Radiographic examination of the

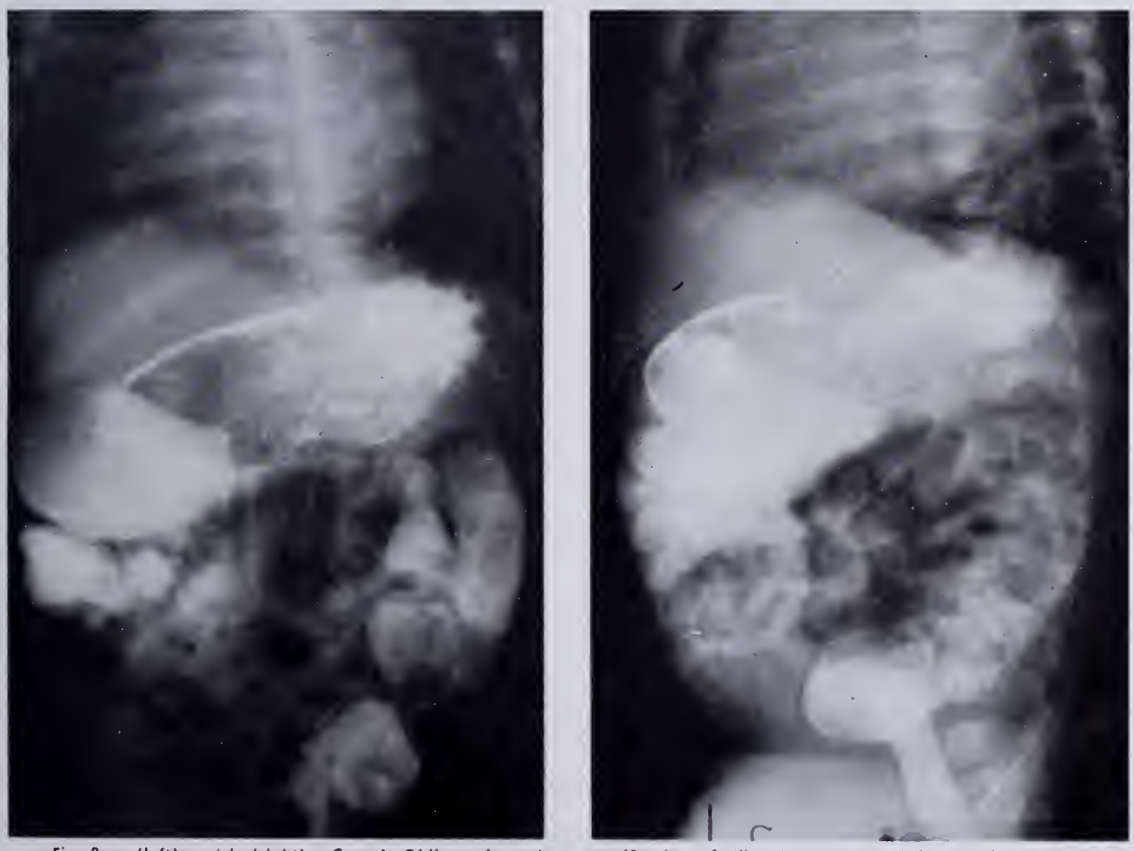

Fig. 2, a (left) and b (right)—Case 1. Oblique views show opacification of dilated stomach and first portion of the duodenum. Opaque material in the left side of the colon represents residuum of barium enema which preceded upper gastrointestinal examination.

Fig. 3—Case 2. Marked gaseous distention of the stomach and duodenal bulb (duodenal atresia was present 3 cm. distal to the pylorus). No gas is seen in the more distal small or large intestines.

right hand revealed a hypoplastic middle phalanx of the fifth finger.

The hospital course was that of progressive dehydration and rapid deterioration. Death occurred four days after birth. The autopsy disclosed numerous congenital anomalies consistent with mongolism. Duodenal atresia was present 3 cm. distal to the pylorus. Proximal to the atresia, the esophagus, stomach, and first portion of the duodenum were dilated. A few millimeters distal to the atresia, the duodenal lumen again became patent as was the remainder of the gastrointestinal tract. Other postmortem findings were stenosis of the left ureter with dilatation above and stenosis of the aqueduct of Sylvius with internal hydrocephalus.

The female twin sibling of Case 2, weighing 4 lb. and 4 oz. at birth, also exhibited the stigmata of mongolism. No gastrointestinal difficulties were clinically encountered. Plain roentgenograms of the abdomen were essentially negative and opaque upper gastrointestinal studies revealed no obstruction in the stomach, duodenum, or remainder of the gastrointestinal tract (Fig. 5).

Discussion. The etiology,[4-8] incidence,[9, 10] and physical findings[11, 12] of mongolism are adequately discussed elsewhere. The roentgenologic findings in mongolism are generally characteristic and well known.[13-15]

The association of mongolism and duodenal obstruction was not widely recognized prior to 1949. The incidence of mongolism in congenital duodenal obstruction is 4 of 17 (Lanman,[3] 1949), 3 of 11 (Grove and Rasmussen,[2] 1950), 10 of 32 (Bodien and associates,[1] 1952). In a study on mongolism and congenital heart disease by Berg, Crome and France,[16] 10 of 141 mongoloids presented were found to have duodenal atresia or stenosis. Eek[17] and Louw[18] also draw attention to this combination.

Duodenal atresia or stenosis is due to abnormal embryological development.[19] During the fifth week of fetal life, there is marked proliferation of the epithelial layer within the duodenum. The duodenum transforms from a hollow tube-like structure into a solid cord-like structure. However, by the twelfth week of fetal life, vacuolization of the inner portion of the duodenum normally results in complete recanalization. Incomplete recanalization may cause varying degrees of intrinsic congenital duodenal obstruction. Atresia is due to complete luminal obstruction which may vary from a thin membrane to complete absence of a segment of the duodenum. Incomplete luminal obstruction or narrowing of the duodenum results in stenosis. Congenital duodenal stenosis may be so minimal as to be symptomless for life or so severe as to give dramatic symptomotology shortly after birth as in duodenal atresia.

Duodenal atresia or stenosis occurs once in 20,000 live births.[20] Atresia in the duodenum occurs less frequently than in the esophagus but more commonly than in the jejunum or ileum.

The diagnosis of congenital duodenal atresia[17, 21] can usually be suspected clinically, shortly after birth, with a rapid onset of vomiting following each feeding, marked dehydration, and progressive deterioration. Congenital duodenal stenosis presents a variable clinical picture. Severe degrees of stenosis will simulate the clinical picture of

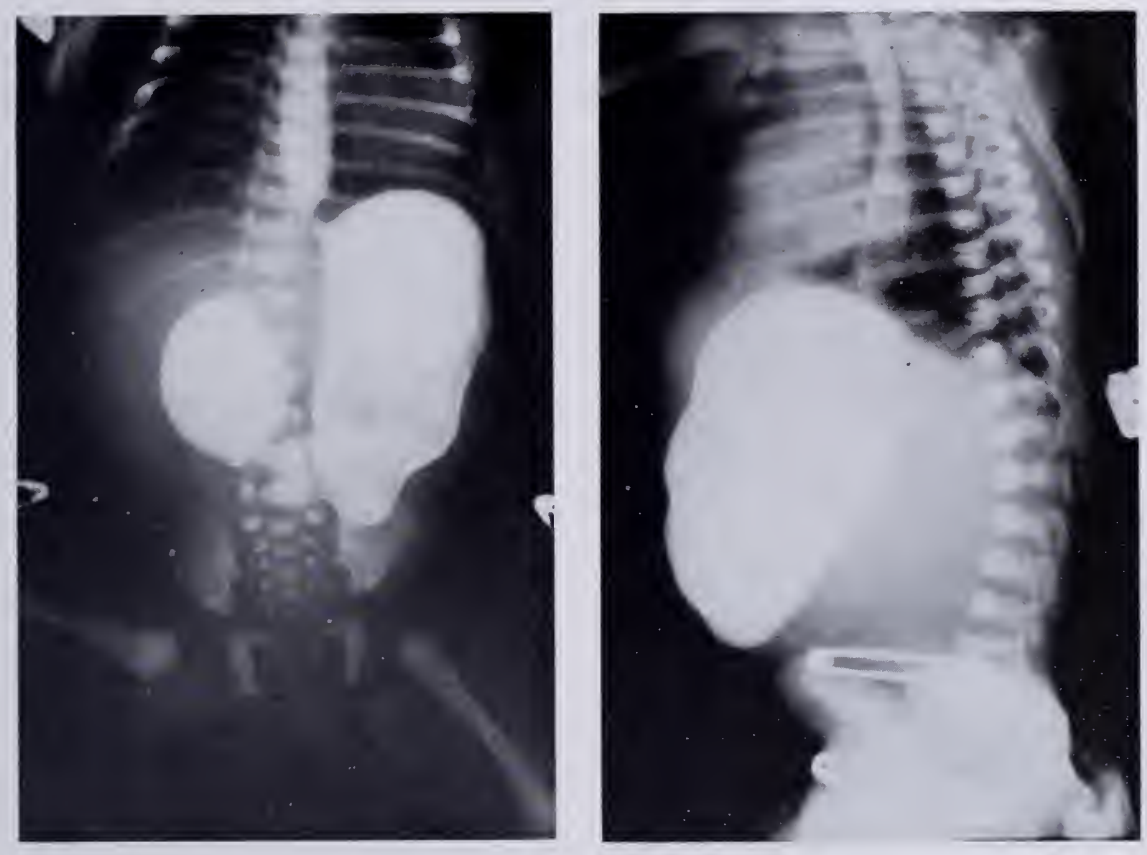

Fig. 4, a (left) and b (right)—Case 2. Anteroposterior and lateral views confirm the presence of complete obstruction distal to the duodenal bulb.

atresia. Moderate degrees of stenosis may give intermittent symptoms of obstruction. Mild stenoses may never become clinically apparent. Vomiting, following each feeding, is the first and most common sign of duodenal obstruction. The vomitus consists of previously ingested food. The presence or absence of bile-stained vomitus depends upon the location of the obstruction—proximal or distal to the ampulla of Vater. Marked abdominal distention frequently is not encountered because of prompt emesis of the recently ingested food. Peristaltic waves across the abdomen from left to right are seen frequently as in pyloric stenosis. The patient is usually restless and soon becomes dehydrated. The stools may be of normal frequency, color, and consistency in duodenal stenosis. In congenital atresia, a few meconium stools may be passed. Farber[22] devised a method of determining whether a congenital gastrointestinal atresia is present. Microscopic examination of the meconium stools fails to reveal cornified epithelial cells in cases of atresia. The cornified epithelial cells, derived from the fetal skin and swallowed with the amniotic fluid by the fetus, do not become part of the meconium because of the lack of patency of the gastrointestinal tract.

The roentgenologic findings of duodenal obstruction are typical. A plain roentgenogram of the abdomen usually reveals two collections of gas corresponding to the stomach and duodenum, proximal to the level of obstruction (Figs. 1 and 3). Gas in varying amounts will be present distal to the obstruction, depending upon the degree of patency, if any. Upper gastrointestinal studies employing opaque media will also show varying degrees of dilatation of the stomach and preobstructive portion of the duodenum. Opaque medium will not pass beyond the duodenum in cases of atresia (Figs. 4 a and b). In stenosis (Figs. 2 a and b), the opaque medium usually passes through the stenotic area into the remainder of the gastrointestinal tract.[17, 23]

Fig. 5—Mongoloid sibling of Case 2, age one month. No obstruction in stomach or duodenum. No gastrointestinal symptoms.

Because of the possibility of aspiration and its sequelae and the adequacy of plain film studies, some authors object to the use or addition of contrast media.[24] Roentgenography following the insufflation of air into the upper gastrointestinal tract usually localizes the obstruction and indicates whether the obstruction is complete or incomplete.

Summary. Since 1949, there has been an increasing awareness of the association of mongolism and intrinsic duodenal obstruction. The incidence, embryological factors, clinical and radiographic findings of congenital intrinsic duodenal obstruction are discussed.

Mongolism is present in 22 to 31 per cent of patients with congenital duodenal atresia and stenosis. Two cases of intrinsic duodenal obstruction in mongoloid individuals are presented.

West Wisconsin Avenue at North 19th Street (3).

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CLINICOPATHOLOGIC CONFERENCE

P C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

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Case Presentation.* A 10-month-old female infant was admitted to the hospital because of diarrhea, vomiting, abdominal distention, and a rise in temperature. The infant had been entirely well until she developed loose stools five days before admission. The stools were described as large, watery, greenish in color, and numbered two to three a day. They contained no blood or mucus. Two days prior to admission the patient started to vomit. The mother continued to offer milk and solids, but none of these foods was retained. The diarrhea subsided and the infant had no further bowel movements. On the day of admission the infant's abdomen was distended, and a rise in temperature was noted for the first time.

There was no history of previous similar attacks of diarrhea and vomiting. The infant's general health had been good. She had been given unpasteurized milk with a good variety of solids and had shown a normal weight gain. There had been no previous serious illnesses, injuries, or operations. She had had no contagious diseases.

The infant weighed only 3 lb. 15½ oz. at birth and was considered premature but otherwise normal. She made good progress and was discharged 20 days later, weighing 5 lb. 12 oz. Subsequent development was normal, and the infant appeared chubby and strong.

Physical examination on admission revealed a well-developed, somewhat chubby, female infant who appeared acutely and seriously ill. She was toxic, dehydrated, and listless. Rectal temperature was 103.4 F. Respirations were 52, regular and shallow. The pulse was 160. The only other positive findings were related to the abdomen which was distended and tympanitic but with no apparent tenderness, masses, or splinting of the abdominal muscles. Digital rectal examination revealed no masses or other unusual findings. The skin was warm, dry, and inelastic.

Laboratory studies showed a white blood cell count of 7,700 per cu. mm. with a differential count of 7 segmented neutrophils, 40 band forms, 39.5 lymphocytes, 7.5 monocytes, 5 metamyelocytes, and 1 myelocyte; a red blood cell count of 4,280,000 per cu. mm.; hemoglobin level of 10.2 Gm. per 100 ml.; occasional basophilic stippling, and normal platelets. Urinalysis showed a pH 6, specific gravity 1.030, albumin 1+, sugar 4+, acetone 3+, and occasional white blood cells. A urinalysis on the next day showed no sugar and a 1+ acetone. Stool culture showed group A, *Escherichia coli*, sensitive to tetracycline and colimycin. A flat x-ray film of the abdomen on the day of admission, in both supine and upright positions, showed a large amount of gas scattered throughout the entire colon and small intestine. The lungs and heart appeared normal.

Electrolyte studies on admission showed a serum sodium level of 124, serum potassium 7.4, and serum chloride 54 mEq./l.

Treatment consisted of continuous intravenous drip of corrective fluids, 200,000 units of penicillin given intramuscularly every 12 hours, and 100 mg. of streptomycin every 8 hours. A Levin tube was passed for gastric suction.

On the morning following admission, the infant appeared better hydrated and more alert. A repeat of the electrolyte studies showed them to be well within normal limits. A surgical consultation was requested. There was less abdominal distention and immediate surgical intervention was deferred. However, that afternoon the infant suddenly developed a generalized convulsion and the rectal temperature soared to 109.0 F. The convulsion was controlled with intravenous administration of amobarbital sodium (Amytal). Intravenous fluids were continued. The urine now showed albumin 2+, acetone 1+, granular casts 3+, specific gravity 1.015. On the second day after admission, the infant's general condition deteriorated. A generalized edema developed

* From St. Agnes Hospital.

with evidence of a markedly decreased urinary output. The infant died 72 hours after admission.

Differential Diagnosis. *Dr. Jane H. Koll:* We are dealing with a severe gastroenteritis with electrolyte derangement. In infants this opens up a large area of possibilities. One would consider first: the gastroenteritis caused by members of the *E. coli* group. These organisms possess pathogenic properties in the alimentary tract of infants but usually not in older persons. The point against this is the abdominal distention.

Intussusception is a common emergency, especially in infants between 4 and 10 months of age. The first symptoms generally are attacks of severe abdominal pain recurring at frequent intervals. If the obstruction continues, the stools are blood-tinged or frankly bloody. This did not occur with our patient. I would be inclined to assess volvulus similarly. A Meckel's diverticulum may be the seat of a pyogenic inflammation similar to appendicitis, but this is rare in infants. But the mere fact of rarity does not rule out its presence, especially in this case.

I am inclined to believe that the stippled red blood cells lead nowhere. Stippled cells are noted in a variety of clinical conditions such as lead poisoning and hemolytic and deficiency anemias of varying severity. In acute lead poisoning, although vomiting and abdominal pain are prominent clinical features, gastrointestinal irritation is seldom remarkable. In chronic lead poisoning there is loss of weight and anemia with encephalopathy which would not apply here. There is no history of drug poisoning which may cause gastrointestinal irritation and acidosis.

The glycosuria and acetonuria suggest the possibility of a diabetic acidosis. However, acetone frequently appears in the urine of children during dehydration of any cause. Diabetic infants are often oversized and overweight, although this infant apparently was not.

A flat x-ray film of the abdomen raised the question of a possible peritonitis with a paralytic ileus. The infant was seen in surgical consultation, and at that time the abdomen was distended and soft; no indication for surgical intervention was entertained. Tenderness and constant involuntary board-like rigidity or spasm of the abdominal wall are characteristic of older children with peritonitis, but young infants may not demonstrate board-like rigidity in the presence of peritonitis. Abdominal distention and some tenderness may constitute the only findings in this age group. Infants with peritoneal irritation lie very still. The hemogram showing a shift to the left points to an overwhelming infection.

The diagnoses that I could consider are diabetic acidosis with an extreme electrolyte derangement and a peritonitis of unknown etiology.

Dr. C. R. Peterson: These findings can be based on an electrolyte derangement. Doctor Pawsat, did you say this had been corrected?

Dr. E. H. Pawsat: Yes.

Clinical Diagnoses. The clinical diagnoses were: (1) acute gastroenteritis with marked toxicity, (2) electrolyte derangement with dehydration, (3) paralytic ileus, (4) intussusception, and (5) perforated appendix.

Doctor Koll's diagnoses were: (1) diabetic acidosis with electrolyte derangement, and (2) peritonitis of unknown etiology.

Pathologic Findings. *Dr. R. W. Steube:* The pertinent findings were related to the abdomen. The abdominal cavity contained 500 ml. of purulent green fluid. This exudate covered all of the abdominal organs and bound together the cecum and loops of terminal ileum. A perforation at the base of the appendix resulted in an almost complete amputation.

Clinicopathologic Correlation. Although acute appendicitis is probably the most common acute surgical illness treated in general hospitals, it is rare in infants under one year of age. In one series of 2,070 cases of acute appendicitis in infants and children, 7 were less than one year of age; 6 per cent of these were ruptured, an incidence of 85 per cent.[1] The rapid progression of inflammation to a generalized peritonitis in infants makes appendicitis a serious disorder and a perplexing diagnostic problem. When a generalized peritonitis develops following a ruptured appendix, there is some difference of opinion regarding immediate and deferred surgery. One cannot deny that immediate operation in an infant who is in a toxic state may result in his failure to recover. On the other hand, deferring surgery for supportive treatment may also result in failure. It has been suggested that in a toxic infant with a pulse rate above 140 and a temperature

above 103.0 F., supportive treatment is advisable.[1] But a fine sense of timing to subsequent surgery is most essential. Parenthetically, it might be added that glycosuria in the patient under discussion was most likely associated with the intravenous administration of fluids containing 5% glucose.

Anatomical Diagnoses. The anatomical diagnoses in our patient were: (1) acute suppurative appendicitis with perforation, (2) generalized purulent peritonitis, (3) focal atelectasis, (4) minimal hydrothorax on the right side, and (5) acute passive pulmonary congestion.

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NEW U. S. DRUG REGULATIONS BRING FEWER PRODUCTS AND BOOST COSTS

The government's restrictive regulations against the drug industry have in one year's time resulted in fewer new drugs and raised manufacturing costs to unrealistic proportions, the Pharmaceutical Manufacturers Association said in a recent issue of *The New Physician*, the journal of the Student American Medical Association.

"Some of the worst fears of a year ago have been realized," the article said, adding: "there have been fewer new drugs; those that have appeared have arrived at a slower pace, and it is costing more than ever before to make a new drug product available."

The article, written by C. Joseph Stetler, Washington, D.C., executive vice president and general counsel of the Pharmaceutical Manufacturers Association, charged that the new regulations call on researchers and sponsors to fill out lengthy government forms, submit detailed investigational plans, and render regular reports as an investigation progresses.

He said that the Food and Drug Administration "now must give its affirmative approval before a new drug can be marketed, and pass on questions of effectiveness as well as safety."

"As a result," Mr. Stetler said, "the regulations have imposed excessive burdens on clinical investigators, destroyed much of the value of trade names, underestimated the physician's intelligence, tended to substitute bureaucratic for scientific judgment, and in some instances they clearly go beyond the intent of Congress."

Mr. Stetler said his Association, representing 140 drug manufacturing firms, completed a survey which showed that "10 pharmaceutical companies, several of them among the nation's major producers of ethical drugs, reported drastic curtailment of research and development operations in 1963."

"One major company reduced its research staff by 55. Another company claims that of 67 agents 'out' for clinical trial as of July 1962, only 17 were continued. Another firm acknowledged that 90 investigations were discontinued, 20 of which were almost complete. Still another company dropped 30% of its projects, though all were rated 'good' to 'enthusiastic' by research personnel.

"Other firms reported a cutback in the number of projects undertaken despite increased research and development expenditures. Two midwestern companies closed their research departments. Others considered initiating more research abroad, and still others merged with stronger firms. It is estimated that a total of 600 investigations planned before the new drug regulations went into effect have been cancelled or postponed."

Another serious drawback, Mr. Stetler said, is "the exodus of research talent to other, less regulated scientific fields."

Continuing, he said:

"Many express the fear there may be fewer drugs in the years to come if the law and regulations are not modified. The trend has been downward since the start of the investigation of the drug industry on December 7, 1959. In that year, a record 62 completely new products were placed on the market. This number fell to 39 in 1960, 34 in 1961 and 28 in 1962. On the basis of early returns, this number may be as low as 14 for 1963.

"Before enactment of the new regulations, it took five to six years, on the average, to place a truly new drug discovery on the market. Unless the regulations are modified, this time may be extended to 10 years. Thus, the tempo of discovery and development could be set back a decade, with other products being delayed until the log jam breaks. The question arises as to how many individuals may suffer or die unnecessarily during this period for lack of a drug that isn't available because of excessive demands in the regulations."

Mr. Stetler pointed out in *The New Physician* article that the survey showed a sharp rise in production costs during the last year.

"The average cost of producing a uniquely new drug product was estimated at 8.5 million dollars before the regulations took effect. Estimates indicate the cost of producing a new drug under the new regulations may approach 10 million dollars. This is due to many factors. Those related to the regulations are increased administrative costs, additional complicated and costly animal testing, and foreign competition. Inevitably, these higher production costs will be reflected in higher prices."

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

New Concepts in the Therapy of Angina Pectoris

By HAROLD F. HARDMAN, M.D., Ph.D.
Milwaukee, Wisconsin

■ CLASSICAL THEORY states that nitroglycerin produces coronary vasodilation thereby increasing coronary blood flow and improving myocardial oxygenation. Honig, Tenney and Gabel[1] are the most recent proponents of this concept and conclude that nitroglycerin relieves myocardial ischemia by enhancing oxygen delivery rather than by reducing cardiac work. Their conclusion is subject to severe criticism on several counts. First it is an indirect conclusion arrived at by exclusion of *some* other possible mechanisms of action of nitroglycerin. Second, their experiments were performed in normal animals in which no attempt to produce myocardial ischemia was made prior to the administration and evaluation of nitroglycerin. Finally, the technique they employed for evaluating the oxygenation of the myocardium showed spontaneous fluctuations which were greater than those changes induced by administration of nitroglycerin.

Other workers propose that coronary blood flow is relatively unaffected by nitroglycerin and attribute relief of myocardial ischemia to reduced work load on the heart with a resulting decrease in cardiac oxygen requirement. Gorlin[2] in particular has endorsed the concept that hypoxemia induces maximal coronary vasodilation via the products of anaerobic metabolism thus preventing any further drug-induced vasodilation. He suggests that most drugs having the capacity to improve myocardial oxygenation do so by reducing the metabolic demands of the myocardium for oxygen.

In recent years laboratory and clinical evidence has accumulated which tends to cast doubt upon the classical interpretation of the mechanism of action of nitroglycerin in the relief of angina pectoris. Some examples of this evidence are provided in the following.

Sarnoff and his co-workers[3] have demonstrated that in any given functional state of the beating heart, the product of the mean systolic blood pressure and the duration of systole per unit of time (tension-time index) is the principal determinant of myocardial oxygen consumption. Levine and Wagman[4] also implicate heart size as an important determinant of myocardial oxygen demand. It is pertinent that increases in these parameters (systolic blood pressure, heart rate and heart size) in clinical studies are not well correlated with the onset of angina pectoris. By contrast, increases in cardiac output or vigor of cardiac contraction often initiate anginal pain. These latter changes are not associated with oxygen demands as great as those caused by increases in heart size, systolic blood pressure or heart rate, indicating that the general relationship of work load to oxygen demand does not appear to be directly involved in the symptoms of angina pectoris. The type of work done by the heart may be more important than the absolute oxygen demand imposed upon the heart in provoking the onset of angina pectoris. Is it not paradoxical that as the heart enlarges in size during congestive failure, which increases the oxygen demand of this organ, the symptom of angina pectoris is often reduced in severity and frequency of occurrence?

It is necessary to review some of the factors which control coronary blood flow in order to appreciate the growing dissatisfaction with the classical concepts of antianginal therapy.

Coronary Blood Flow Regulation.

A. Blood Pressure: The arterial blood pressure or more specifically the diastolic blood pressure is essential for maintaining blood flow in the coronary arteries. There is some controversy over the quantitative importance of this head of pressure in determining coronary blood flow under physiological conditions. Braunwald and associates[5] have demonstrated that increasing cardiac output through increased venous return at a constant aortic pressure can produce an increase in coronary blood flow.

Autoregulation in the coronary vascular bed has been established by Eckel and associates[6] in the laboratory. These workers varied perfusion pressure in cannulated coronary arteries in the open chest dog without altering cardiac output, heart rate or systemic arterial pressure. When coronary perfusion pressure was suddenly elevated, coronary blood flow increased initially but returned toward control values even though the perfusion pressure was maintained at the new level. In the same way rapid reductions in coronary perfusion pressure were accompanied by sudden decreases in coronary flow which were followed by increases in flow toward control values.

B. Extravascular Compression: The importance of the compression of the coronary vessels in the regulation of blood flow through the myocardium has not been completely settled. Wiggers[7] stated that the cardiac muscle contractions served to massage the coronary vessels and thereby forced blood through these vessels during systole which in turn allowed for greater filling of the vessels during diastole. Sabiston and Gregg[8] observed that asytole produced by vagal stimulation and ventricular fibrillation produced a 59 and 26 per cent increase in left coronary inflow respectively in the dog heart. The authors interpret these findings as representing the degree to which myocardial contraction impedes coronary blood flow.

Eckstein and co-workers[9] reported that sympathetic nerve stimulation produced an increase in contractile force which resulted in a temporary increase in coronary sinus outflow with a concomitant decrease in left coronary artery inflow in open chest dogs. No sustained increase in total coronary blood flow was recorded. They concluded that there was no self-propulsion of blood through the myocardium by a massaging action of the heart muscle.

C. Neurohumoral Factors: The physiological role of the cardiac sympathetic fibers has not been determined. The overall tonic effect of the cardiac nerves appears to be vasoconstriction. This tonic action may be due principally to the sympathetic nerves of the heart; however, some evidence suggests that tonic constrictor activity is due to the vagal fibers. It has not been determined whether the decrease in coronary blood flow resulting from cardiac sympathetic nerve stimulation represents true coronary artery vasoconstriction or is secondary to the associated increase in extravascular compression (the increase in contractile force due to cardiac sympathetic nerve stimulation).

A sustained decrease in coronary blood flow has been observed by Berne[10] with epinephrine and norepinephrine in the potassium arrested heart. Under these conditions the extravascular compression effect of the catecholamines was minimal.

In the isolated dog heart perfused by a donor animal, Hashimoto and co-workers[11] obtained a coronary vasoconstrictor response with epinephrine and norepinephrine when the metabolic effect of these compounds was blocked by dichloroisoproterenol. An enhanced vasodilator response to epinephrine and norepinephrine was observed when phenoxybenzamine was previously administered.

Saito[12] observed that the coronary arteries of the isolated rabbit heart responded to epinephrine by showing a vasoconstrictor response. If fluoroacetate was employed to inhibit cardiac oxidative metabolism, then epinephrine produced a vasodilator response.

The work reported by Hashimoto and associates[11] and the studies of Saito[12] suggest that the vasomotor effect of the cardiac sympathetic nerves is predominantly vasoconstrictor. The vasodilator response, which often overrides the vasoconstrictor response, appears to be secondary to the increase in metabolic activity initiated by the catecholamines. It seems that the cardiac nerves exert some control but are not basic to the changes in coronary resistance that occur with alteration in myocardial metabolism or cardiac oxygen supply.

D. Metabolic Factors: Numerous studies have suggested that the metabolic activity of the myocardium plays a key role in the deter-

mination of coronary blood flow. Oxygen consumption of the arrested and fibrillating heart is less than that of the beating or working heart. With cardiac arrest or ventricular fibrillation there is a large immediate increase in coronary blood flow and coronary sinus blood oxygen content due to removal of extravascular resistance. This rise in coronary blood flow is followed by an increase in intravascular resistance as a steady state is reached and coronary flow decreases to a value below that obtained in the beating heart. This reduction in coronary flow occurs even though coronary perfusion pressure is held constant.

The observation that in the normal heart coronary sinus blood oxygen content is low under a variety of physiological conditions supports the idea of metabolic regulation of coronary blood flow. Cardiac muscle in particular appears to be anatomically arranged for some type of intrinsic control of its blood supply because of the short diffusion pathway between the perfusing blood and the interior of the myocardial cell.

1. HYPOXEMIA: Hypoxemia is considered to be the most potent stimulus known for relaxing coronary vessels and increasing coronary blood flow. Berne and associates[13] studied the effect of hypoxemia on coronary blood flow in the beating and in the fibrillating heart in which coronary vessels were overperfused by means of high perfusion pressures. Under these conditions the coronary sinus blood was rich in oxygen and reduction in arterial blood oxygen content resulted in greater extraction of oxygen from the blood perfusing the myocardium without a concomitant increase in coronary blood flow. At normal perfusion pressure, hypoxemia of similar magnitude elicited a large increase in coronary blood flow. If coronary sinus blood oxygen content remained above 5.5 vol. % during the hypoxemia period, coronary blood flow was essentially unchanged, whereas it increased proportionately with reduction of coronary venous blood oxygen content below this level. It was concluded that arterial blood pO_2 was not a critical factor in the vasodilation seen in hypoxemia but that myocardial pO_2 as reflected by coronary venous blood pO_2, may be responsible for inducing the coronary vasodilation. A further question must be considered which asks whether the decrease in venous coronary oxygen content per se is the receptor mechanism for inducing vasodilation or is this response mediated by some chemical intermediate liberated from the heart in response to the low venous coronary oxygen content?

2. ADENINE NUCLEOTIDES: These compounds are known potent vasodilator substances and for years attempts have been made to link them with the local regulation of muscle blood flow. Within this class of compounds adenine nucleotide, adenosine, ATP and ADP are the most potent vasodilator substances.

Adenosine is rapidly inactivated by deamination to inosine and has a large potential source in the form of muscle adenine nucleotides. These properties make it a plausible candidate for a role in the metabolic regulation of coronary blood flow. Furthermore, the metabolic products of adenosine, inosine and hypoxanthine have been shown to be released from heart muscle during myocardial hypoxia.

The most attractive hypothesis at present is that a reduction in myocardial pO_2 leads to a breakdown of adenine nucleotides with the release of adenosine from the cardiac muscle cells. This causes vasodilation of the coronary vessels with a resulting increase in coronary blood flow. The increase in coronary blood flow elevates the myocardial pO_2 content to the control value with a reduction in nucleotide degradation as the oxygen deficit is corrected.[14]

One of the newer drugs, dipyrimadole (Persantin), introduced as a therapeutic agent for angina pectoris has been reported to inhibit adenosine deaminase.[15] This action would serve to prolong the vasodilator activity of adenosine within the coronary circulation by preventing its breakdown into the inactive metabolite, inosine. Within the framework of this concept, dipyrimadole would be most effective in the presence of myocardial hypoxia and have relatively less importance during intervals of normal cardiac metabolic demands.

Therapeutic Agents.

A. Glyceryl Trinitrate (GTN): Modell[16] indicates that GTN relaxes all types of vascular smooth muscle including that found in arterioles and venules. He questions why GTN is effective in relieving effort-induced

vascular pain in the chest when it does not relieve pain of vascular origin in the extremities (intermittent claudication) which is induced by the same stress of increased activity. Since GTN is not effective in relieving the pain of coronary insufficiency due to atherosclerosis or the pain of peripheral intermittent claudication resulting from inadequate blood flow through sclerosed vessels, he expresses the hypothesis that GTN can only antagonize localized spasms in vessels of normal structure. An alternate explanation might consider the possibility that GTN is effective in treating angina pectoris because it acts through some mechanism other than vasodilation.

B. Dipyrimadole (Persantin): A recent evaluation of dipyrimadole by De Graff[17] indicated that this compound was an effective vasodilator agent in animals and man. Unfortunately, double-blind clinical trials have failed to demonstrate any advantage of dipyrimadole over a placebo in the treatment of angina pectoris. Here is an example of an agent of proven coronary vasodilator activity which appears to have little value in the treatment of angina pectoris. Perhaps the problem of interpretation of these findings is related to inadequate methodology for evaluating antianginal activity, or the problem may lie in our ready acceptance of the hypothesis that angina pectoris is due to coronary artery vasoconstriction rather than to some other cause.

C. Monoamine Oxidase Inhibitors (MAOI): Horwitz and Sjoerdsma[18] produced angina with standard treadmill exercises in five patients during periods of placebo therapy and treatment with the monoamine oxidase inhibitor, pargyline. Each subject showed a significant increase in exercise tolerance during MAOI therapy. Improvement in angina during drug therapy correlated with decreasing levels of blood pressure, heart rate and cardiac output prevailing during exercise. Such alterations in cardiovascular responses to exercise were interpreted as reflecting decreased cardiac work. This concept was proposed by the authors as a basis for the favorable effects of monoamine oxidase inhibitors in some patients with angina pectoris. Here is an example of an effective antianginal agent which lacks outstanding direct vasodilator activity.

Conclusions. The inadequate scientific foundation for the classical concept regarding the mechanism of action of glyceryl trinitrate as an antianginal agent is emphasized. The major support for the concept that anginal pain is due to spasm of the coronary arteries is based upon the observation that GTN can relax coronary vascular smooth muscle. The drug may possess many other pharmacological actions which will provide a better correlation with antianginal activity than does coronary vasodilator potency. This can be explored through comparative studies with other agents like the monoamine oxidase inhibitors whose antianginal activity can be measured clinically and whose pharmacological properties differ in many ways from the pharmacological properties of GTN.

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the WISCONSIN MEDICAL JOURNAL
Published Monthly

JUNE 1964

Vol. 63 No. 6

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Economy-Size Friend

■ WHAT FUN it must be to count somebody else's money from afar and then decide his income should be federally regulated! The sport is harmless except to the victim, and the player comes away from it with an air of righteousness and of being a Friend-Of-The-People. And by making doctors the victim of the game, the fun is even better: they obviously have lots of money which they acquired because people need medical care, and the person who proposes a reduction in the cost of medical care is clearly a great Friend-Of-The-People.

Not infrequently in recent years it has been proposed that the federal government regulate the cost of medical care. For the most part, the proposals have taken the form of tax supported subsidy of a universal nature which would operate to fix the costs of medical service. The wisdom of our democracy has so far avoided such programs, and it is to be hoped that if any plan for tax-supported medical care is legislated, it will be so limited as not to interfere with the relationships that have produced the high level of medical service Americans enjoy today.

All plans for regulation, however, should be examined, and it may be instructive to consider the suggestion made in a paper presented to the American Association for the Advancement of Science last December by Manuel Gottlieb, professor of Economics at the University of Wisconsin in Milwaukee. This particular proposal is of interest because it has the earmarks of a dispassionate study, couched in the terms of a legitimate academic presentation, and offered by a scholar of respectable reputation.

Professor Gottlieb addresses himself to the problem of pricing of medical care in contemporary America. Specifically, he asks how well "competition can function as an ordering mechanism in the medical market." He points out that certain conditions must be met if "the competitive principle" is to be relied upon to achieve satisfactory results in any field of economic endeavor."

It will come as a surprise to practically no one that Professor Gottlieb discovered that the conditions weren't met and that the competitive principle was not operating to regulate prices in the "medical market." He states that average medical earnings rose nearly three times between 1940 and 1950 and "have apparently nearly doubled again in the

decade of the Fifties. The differential of medical over all professional earnings, found at 137–140% between 1929–1940, had risen to 162% in 1950 and in 1959 was probably somewhat higher." Therefore, concluded Professor Gottlieb, the supply of doctors should be increased. Here no doctor will dispute him. The profession itself has undertaken programs to accomplish this goal, and the number of doctors being graduated from medical schools is indeed being increased. He then finds that group health programs under trade union auspices or under the control of other lay or consuming groups is desirable as a "countervailing" influence. And, finally, he concludes "this issue would seem to call for regulation with respect to the level of fee schedules and the abolition of the right to levy discriminatory (sic) charges . . . the right and obligation of public control cannot be denied in a field of occupation endeavor where the competitive principle is so severely restricted and where a dangerous amount of economic power is concentrated in a few hands."

With becoming modesty Professor Gottlieb points out that he has no expert knowledge of the problem of medical care. It requires no expert knowledge, however, of either the problems of medical care or of general economics to recognize that he is, in effect, comparing peppermills with pomegranates and concluding that peppermills should be forced to function as though they were pomegranates.

Contrary to Professor Gottlieb's statement of the problem, there is no such thing as a medical market. Health care is not a commodity that can be packaged, priced, compared, or shopped for. The very nature of medical practice precludes what Professor Gottlieb calls the competitive principle. Only to the extent that a patient is free to obtain the services of another doctor if he is unhappy with the one who is treating him can the patient shop around for medical care. And only when the medical procedure is elective or anticipated can the patient "bargain" over rates. But most medical care is immediate, requirement for it generally unexpected, and its rendering frequently of an emergency nature. The patient-doctor relationship, therefore, must be one of familiarity and confidence—if not confidence based on knowledge of what the doctor has done, certainly confidence based on a reliance of the prevailing high quality of medical care available to the community.

One of the valid points Professor Gottlieb makes is his observation that some doctors—in decreasing numbers, he admits—charge some patients more for a given service than they charge others. Without defending the practice, it should also be observed that some patients are charged less for a given service than most patients pay, and some patients don't pay at all. This however, is a private matter between the patient and the doctor, and if the patient believes he has been overcharged, he is free to form a relationship with another doctor.

The service a doctor offers is personal, predicated on his training, his skill, his intelligence, his devotion to his patients, and his sense of responsibility. His earning capacity, in terms of his service, is limited by the time he can devote to his practice and the income level of his patients. To attempt to regulate the earnings of his practice assumes that he is a machine producing a uniform product for uniform compensation. Nothing could be farther from reality.

If Professor Gottlieb objects to the fact that doctors have made more money in recent years vis-a-vis other professionals, he overlooks the fact that there are more people in our country, more people with more money, more voluntary insurance to enable them to pay for medical services rendered, and fewer doctors relative to the entire population.

The dangerous fallacy of Professor Gottlieb's paper, however, is the very suggestion that the government act to limit the earning capacity of a private individual. If Professor Gottlieb is serious in suggesting such regulation of doctors, he should have no objection to the regulation of the earning capacity of lawyers, engineers, plumbers, TV repairmen, machinists, typists, clerks and, perish the mark, teachers. He might wind up with an economy where the competitive principle is eliminated not only in what he calls the medical market but in all markets. —D.N.G.

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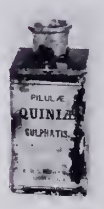

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THANKS

DR. SPENCER BEEBE, Sparta, for the hand-carved replica of the horse and buggy used by Doctor Beebe in making his rounds more than a half-century ago.

The meticulously authentic replica was created and presented to Doctor Beebe by an old friend, Cleo (Rusty) Jeffers of Tomah on behalf of the Jeffers family. Mr. Jeffers, who has had no formal art education, began the project on Nov. 20, 1963, spending 8 to 10 hours a day working from memory. The two figures in the buggy, seen below, are Doctor Beebe on the right and Mr. Jeffers' father who used to drive for Doctor Beebe. In accepting the replica in January 1964, Doctor Beebe, who is 94 years old, commented that it was good enough that he wanted others to see it; therefore, he presented it to the Section on Medical History of the State Medical Society. It is currently on display in the Council Room of the Society headquarters, Madison, and later will be exhibited in the Museum of Medical Progress at Prairie du Chien.

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Late Radiation Necrosis of the Brain

CASE REPORT

By ARTHUR CHANDLER, M. D., FRANCIS C. TUCKER, M. D. and EUGENE E. HERZBERGER, M. D., Monroe, Wisconsin

■ ALTHOUGH THE adult brain is relatively radioresistant, a sufficient dose of ionizing radiation may produce an acute meningoencephalitis, or a late necrosis which becomes apparent only after a latent period. The acute form of radiation injury following massive single-dose irradiation to the entire brain is a violent and dramatic clinical event, of particular recent interest because of its importance in atomic disaster. Late radiation necrosis as encountered in clinical practice, on the other hand, usually follows irradiation to a portion of the brain in the course of radiation therapy for a malignant lesion of the scalp, skull, or central nervous system. Numerous reports have been published. The clinical manifestations will depend upon the site and volume of the irradiated brain and the dose delivered. The latent period is likewise variable, and in some instances may be long enough that the relationship between irradiation and brain abnormality is not one of obvious cause and effect.

Pathology. Late radiation changes in the central nervous system have been described with or without associated vasculitis. In an experimental study of the effects of betatron irradiation on the monkey brain, Arnold and associates[1] noted rather sudden onset of demyelinization, after the clinical latent period, followed by encephalomalacia particularly involving the white matter, including glial cells and axons. The brain stem seems most susceptible to radiation necrosis, while the Betz cells are particularly resistant. Occlusive vascular changes are described as a prominent feature in most reports, in addition to the direct radiation effect on nerve tissue. Hyalinization of the arterial wall is described by Courville and Myers[2] as the most common vascular change, and is well illustrated in their report. The formation of amorphous amyloid matter from degeneration of astrocytes has been described.[3] Bailey[4] noted an inhibition of astrocyte proliferation during the first three years following exposure, after which brisk astrocytosis was again resumed.

Case Report. The patient, a 59-year-old housewife, was first seen in October 1961, complaining of aching in her knees of many years duration. She also reported that she had experienced frequent frontal headaches all of her life. In 1943, 27 radon seeds were implanted in a subcutaneous neurofibrosarcoma in her right temple. The tumor mass subsequently subsided, leaving atrophic skin and subcutaneous tissues.

On Aug. 31, 1962, she developed a severe bilateral frontoparietal headache radiating to the jaw and left arm. When she was seen the next day, symptoms had subsided; an

From the Departments of Radiology (Doctor Chandler) and Neurosurgery (Doctor Herzberger), of The Monroe Clinic; and Pathology (Doctor Tucker) of St. Clare Hospital.

Fig. 1a (left) and 1b (above)—Anteroposterior and lateral views from the right carotid arteriogram series, showing posteromedial displacement of the anterior cerebral artery. The radon seeds (superficial to the skull) are also seen.

electrocardiogram was interpreted as normal. Several days later she complained of severe pain in the lumbosacral region. She was hospitalized and was observed to have occasional hallucinations. A lumbar puncture was performed and xanthochromic spinal fluid was obtained.

Bilateral carotid arteriograms were performed. These demonstrated the presence of a mass lesion producing posterosuperior displacement of both anterior cerebral arteries as shown in the lateral projection, and medial displacement of the right anterior cerebral artery as seen in the frontal film. There was corresponding lateral displacement of the left anterior cerebral artery. Films from the right carotid arteriogram are shown in Figures 1a and 1b, which also show the location of the radon seeds, low in the right frontal region superficial to the skull.

A right fronto-temporal craniotomy was performed on Sept. 24, 1962. The brain was moderately tense. The lower portion of the right frontal lobe and the tip of the temporal lobe showed a yellow-blue discoloration. Puncture of the brain with a ventricular needle revealed the presence of two large intracerebral cysts. One was located in the frontal lobe and extended toward the basal and medial aspects of this lobe. The other was in the temporal pole. Both cysts contained yellowish viscid fluid. Their walls were smooth but without any lining membrane. Both measured about 5 cm. in diameter. The cysts were drained and portions of the abnormal brain overlying the cysts were removed for microscopic study. Figure 2 shows the right fronto-temporal brain surface at the time of craniotomy demonstrating discoloration of the surface and a portion of the cavity of the frontal cystic lesion after incision.

Microscopic examination revealed hemosiderin deposition in the walls of the cysts, perivascular accumulation of lipid phagocytes and protein-rich fluid, hyaline thickening of blood vessel walls, demyelinization of white matter, and proliferation, with swelling and hypertrophy, of astrocytes. These

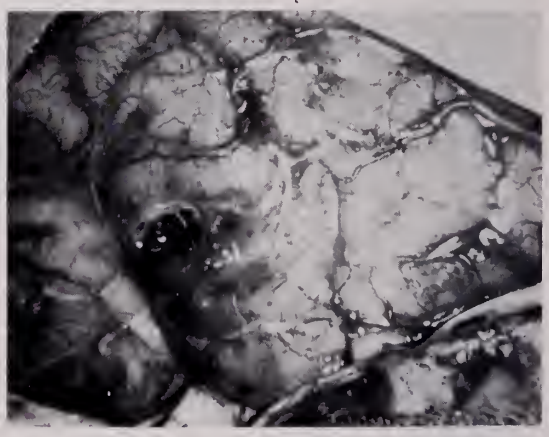

Fig. 2—Surface of brain showing lower frontal lobe and temporal tip. Cyst in frontal lobe has been incised. Brain surface discolored over and adjacent to cyst.

Fig. 3a—Photomicrograph of cyst wall containing hemosiderin deposition. There is no actual membrane surrounding the cyst.

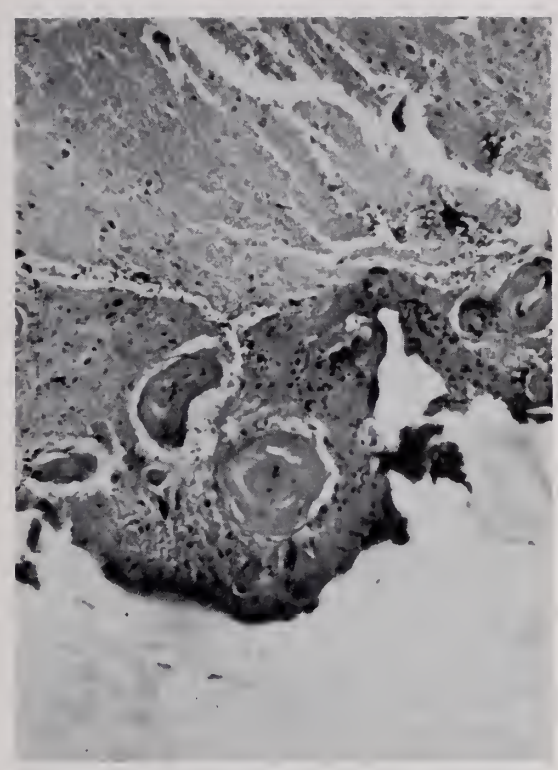

Fig. 3b—Photomicrograph showing hyaline thickening of the blood vessel walls.

findings were considered to be consistent with late radiation necrosis of the brain.

The postoperative course was uneventful and the patient was dismissed from the hospital six days following the operation. Her hallucinations have subsided, and she is able to resume her full household duties.

Discussion. The cumulative dose to the right frontal lobe is approximately 7,000 gamma-roentgens at 2 cm. depth, 3,300 at 3 cm., and 1,800 at 4 cm. In the widely quoted papers of Boden,[5,6] the tolerance dose of radiation for the brain stem and spinal cord is stated as 3,500 r in 17 days for large fields and 4,500 r in 17 days for small fields. These figures serve as useful guides in clinical radiation therapy, bearing in mind that the function of the irradiated site is also of importance; thus, a small degenerative lesion in the brain stem might prove fatal, while a similar volume of destruction in the frontal lobe might pass undetected. Obstruction of the aqueduct and outlets of the fourth ventricle may occur if these structures lie in heavily irradiated fields.

The cyst-like nature of the lesions in this patient is of interest; the arteriograms demonstrate the expansile nature of the process. Since no membrane surrounded the cysts, it is unlikely that there was an osmotic gradient with passage of fluid into the lesions such as may occur in chronic subdural hematoma. Hemorrhage into the lesions may have caused the expansion.

Also of interest is the long period between the time of the implant and the development of symptoms. In the majority of cases reported, this time interval is under two years. The location of the lesions in the frontal lobe and anterior portion of the temporal lobe probably allowed this patient to pass through the stage of necrosis without symptoms. It is possible that cystic necrosis might be observed more commonly in the natural history of late radiation necrosis of the brain, were it not that significant symptoms usually appear at the time of the demyelinization and encephalomalacia, leading either to death or surgical intervention at that time. Similarly,

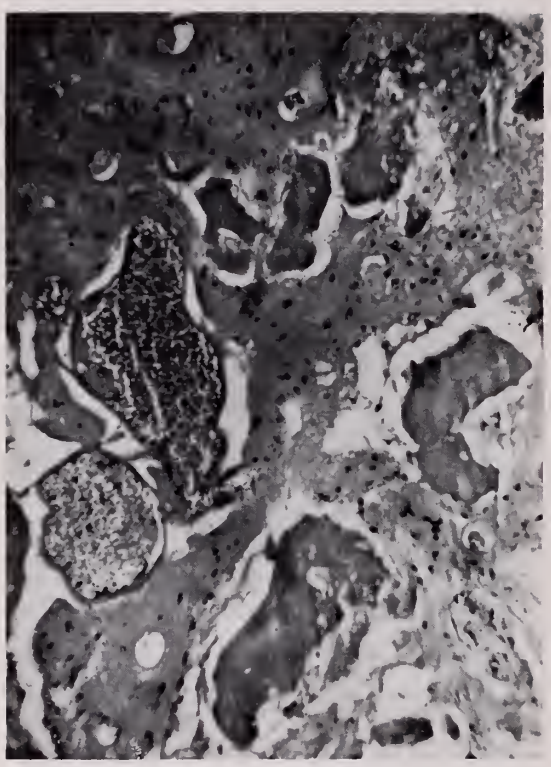

Fig. 3c—Photamicrograph of necrotic brain adjacent to cystic cavity, showing accumulations of pratein-rich fluid.

in experimental studies, the animals are generally killed within a few months of irradiation, and this may be too short an interval for the full evaluation of the chronic degenerative process.

Differential Considerations. In the diagnosis of mass lesions developing years after radiation therapy, radiation-induced neoplasia must be considered.

Fibrosarcoma, particularly, has been described developing many years after irradiation to the brain,[7] although other tumor types may be induced.

Summary. A case is reported in which late radiation necrosis of the brain was found 19 years after radon implantation of a malignant neoplasm of the scalp. Interest centers on the long latent period between radiation and onset of symptoms, and on the expansile, cystic nature of the degenerative lesions.

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NEW NURSING BOOKLET RELEASED

Do You Want to be a Nurse?, new recruitment booklet for professional and practical nursing, has been released by the Committee on Careers, National League for Nursing, New York. The 24–page illustrated pamphlet was written to tell high school students, their advisers and parents, about the four basic educational routes to nursing and the career opportunities to which they lead.

In announcing the publication's release, Fred C. Foy, chairman, Committee on Careers, stressed the need to encourage a higher percentage of high school graduates, both men and women, to enter schools of professional nursing.

Single copies of the booklet may be obtained free of charge by writing the Committee on Careers, 10 Columbus Circle, New York, N. Y. 10019. The unit price is 10¢, and in quantities the prices are: 10 copies, $7.50; 500, $25.00; and 1,000, $45.00. The Committee on Careers is the national clearing house for information on careers in nursing. It is co-sponsored by the American Hospital Association, American Medical Association, American Nurses' Association and National League for Nursing.

BOOKLET: FAMILY THERAPY

A new Public Affairs Pamphlet No. 356 entitled FAMILY THERAPY—HELP FOR TROUBLED FAMILIES by George Thorman is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y., 10016. Mr. Thorman shows how family therapy can reduce conflict among family members and teach compromise and, even better, cooperation.

CASE REPORT

Idiopathic Pulmonary Hemosiderosis

By JOHN M. IRVIN, M. D.
Monroe, Wisconsin

■ IDIOPATHIC pulmonary hemosiderosis (IPH) is a rare and usually fatal disease that is characterized by diffuse recurrent pulmonary bleeding with hemoptysis, transient pulmonary infiltrates, and secondary anemia in the acute stage and diffuse pulmonary hemosiderosis with progressive pulmonary fibrosis and cor pulmonale in the chronic stage. It generally occurs in children but has been reported occasionally in adults.

The following is a case report of a 12-year-old boy who was observed for the six years of his illness and who died of progressive heart failure. The autopsy findings were those of IPH with endomyocardial fibroelastosis and necrotizing arteritis. His serum had precipitins to wheat gliadin and cow's milk.

Case Report. A 12-year-old boy, of Norwegian descent, first became ill in 1954 when at the age of 6 years he developed progressive fatigue and pallor. He weighed 39 lbs. and was 43 in. tall. A grade 2 systolic murmur was heard at the left sternal border. The liver was palpable just below the right costal border. His hemoglobin level was 3.6 Gm. per 100 ml. and the red blood cell count was 2,900,000 per cu. mm. With orally administered ferrous gluconate, the hemoglobin level rose to 12.0 Gm. per 100 ml. in six months.

A mild secondary anemia was noted again in 1956 which persisted despite orally given iron. In November 1957 he was given 400 mg. of iron-dextron complex (Inferon) in four intramuscular doses of 2 ml. each. There was a prompt response with the hemoglobin level reaching 12.9 Gm. per 100 ml. in two months.

In November 1959, he was first admitted to the hospital complaining of shortness of breath on exertion, fatigue, and dizzy spells of one month's duration. He spit up mouthfuls of bright red blood on several occasions during this period. It was noted that he had mild intermittent diarrhea since infancy which suggested a mild sprue syndrome. He weighed 69 lb., was pale, and appeared chronically ill. A grade 2 systolic murmur was heard at the left sternal border in the second, third, and fourth interspaces. The pulmonic second sound was snapping in character, accentuated, and greater than the aortic second sound. The blood pressure was 100/40 mm. Hg. The red blood cell count was 2,160,000 per cu. mm.; hemoglobin level, 6.7 Gm. per 100 ml.; white blood cell count, 4,500 per cu. mm.; hematocrit reading, 26%; differential count was normal except for 7% eosinophils and 6.3% reticulocytes. The sputum contained many macrophages laden with hemosiderin. The sternal bone marrow showed marked erythroid hyperplasia. X-ray films of the chest demonstrated generalized cardiac enlargement and of the upper gastrointestinal tract showed puddling of the barium in the small intestine suggesting a malabsorption syndrome. Direct Coombs test was negative. Urinalysis was normal. The stool was negative for occult blood. He was given 400 mg. of iron intramuscularly in divided doses, and the hemoglobin level reached 8.2 Gm. per 100 ml. in one month.

He again entered the hospital in February 1960 with diarrhea, abdominal cramps, and increased pallor of one week's duration. He had spit up mouthfuls of bright red blood on several occasions. The physical findings were essentially as on the previous hospital admission. The x-ray film of the chest again showed generalized cardiac enlargement, as well as a diffuse fine reticular infiltration in the central portions of both lungs. The hemoglobin level was 5.7 Gm. per 100 ml. and the hematocrit reading was 20%. The white blood cell count was 7,650 per cu. mm. with a normal differential of which 1% were eosinophils. The stool was negative for occult blood. The electrocardiogram showed a sinus tachycardia, low T waves throughout, and mild left ventricular preponderance. The red blood cell osmotic fragility test was normal. The patient was given a transfusion of 1,000 ml. of whole blood and was discharged a week after admission.

He was admitted to the hospital Apr. 3, 1960, for the third time with an exacerbation of the anemia. He had had an upper respira-

tory infection with watery nasal discharge and sneezing for two weeks, tightness of the chest, shortness of breath, and coughing up of bright red blood for three days. Fine crepitant râles were present at the lung bases. The heart was enlarged to the left. A grade 2 systolic murmur was heard at the left border. Both pulmonic first and second sounds were accentuated. The pulmonic second sound was markedly increased and snapping in character and again greater than the aortic second sound. The first heart sound at apex was split. There was early clubbing of the fingers. X-ray film of the chest demonstrated marked cardiac enlargement involving both ventricles, and there was moderate pulmonary congestion in the central lung fields with a fine reticular infiltrate. Macrophages laden with hemosiderin were found in the morning gastric aspiration. Serum iron was 0.03 mg. per 100 ml. (normal, 0.06 to 0.18 mg. per 100 ml.). The hemoglobin level was 10 mg. per 100 ml.; hematocrit reading 32%; white blood cell count, 4,500 per cu. mm. with a normal differential count. The LE cell test was negative. There was prompt symptomatic improvement with oral administration of digitoxin and hydrochlorothiazide.

On Apr. 13, 1960, he was referred to an out-of-state clinic where right and left cardiac catheterization was done. The report of this examination was as follows: "The left ventricular pressure was 97/6–26, with a 'square root sign' and a high end-diastolic filling pressure. The pulmonary artery wedge pressure was 26/17. The cardiac output was 31 L/min/M^2. Dye dilution curves showed prolonged circulation times with probable slow clearance from enlarged chambers. Angiocardiograms showed dilatation of the main pulmonary artery, left atrium, and probably left ventricle."

He returned home after two weeks; and because of persistent dyspnea, hemoptysis, and anemia, prednisolone was given orally on May 18, 1960, with an initial dose of 40 mg. and a maintenance dose of 20 mg. daily. There was symptomatic improvement with increase in appetite, decrease in dyspnea, and increase in weight. The hemoglobin level rose from 10.0 to 12.8 Gm. per 100 ml. by July 1960 at which time signs of hyperadrenocorticism with moon-facies were noted. In August, precipitins in significant titer for wheat gliadin and precipitins to milk protein in low titer were found in the serum.* Wheat and milk were eliminated from the diet without apparent benefit.

On Sept. 4, 1960, he was admitted to the hospital with severe pain and tenderness in the right flank of 12 hours' duration. The hemoglobin level was 9.8 Gm. per 100 ml. The urinalysis was normal except for a strongly positive test for acetone The excretory urogram was normal. He had a temperature as high as 103 F. on the first two days but was afebrile by the third day and was discharged the fifth day.

Following discharge from the hospital, heart failure progressed despite adequate doses of digitoxin and hydrochlorothiazide. Crepitant râles were present at both lung bases and the heart was greatly enlarged. On Oct. 1, 1960, the hemoglobin level was 8.7 Gm. per 100 ml. He was referred to the out-of-state clinic on Oct. 18, 1960, and he died 10 days later of heart failure.

The autopsy was performed by the pathology department of this clinic. The heart was greatly enlarged and weighed 350 Gm. (normal estimated weight was 150 Gm.). Part of the enlargement was due to hypertrophy and part due to dilatation of the chambers, especially the left ventricle. The pulmonary outflow tract was greatly dilated and measured 2.6 cm. in diameter, 1.0 cm. above the valve cusps. The myocardium of the interventricular septum and the free wall of the left ventricle showed foci of fibrosis. The endocardium of anterior and septal portions of the left ventricle showed the typical thickened, pale plaques of fibroelastosis. The coronary arteries were smaller than normal for a child of this age, especially the right coronary artery distal to the right marginal branch and the circumflex branch of the left coronary artery. The posterior descending artery was extremely small.

The lungs were heavy, firm, and the surface of the upper and anterior lower lobes appeared rusty-brown in color. The surface of the posterior lower lobes was dark bluish purple. Cut surface of the upper and anterior lower lobes was rusty-brown in color and contrasted with the dark reddish appearance of the posterior segments of the lower lobes. The right lung weighed 420 Gm. and the left 350 Gm. Edema fluid ex-

* The precipitins to wheat and milk were found by Heiner and his associates at the University of Utah Medical School in a study on celiac disease.

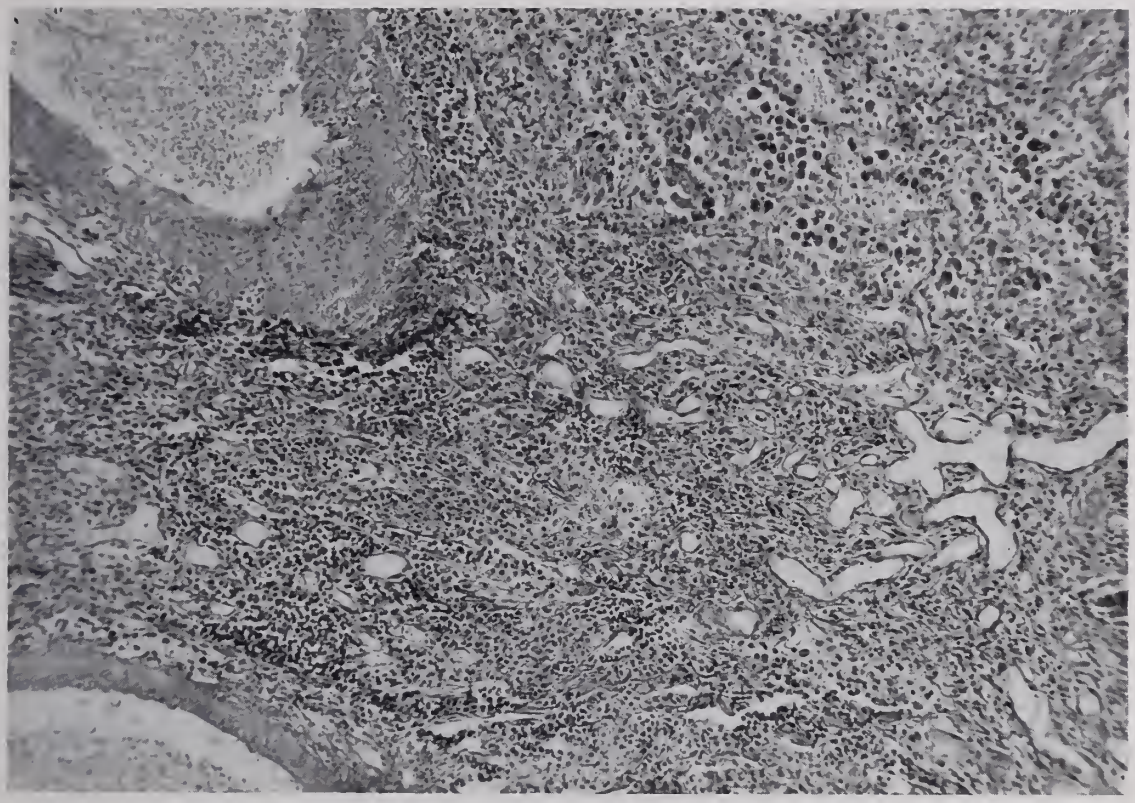

Fig. 1—Microsection (120 X) of the lung showing round cell infiltration of the wall and adjacent tissue of a medium-sized artery. The alveali are filled with hemosiderin-laden macrophages.

uded from the cut surface with compression. The hilar lymph nodes were moderately enlarged.

The only other gross abnormality was found in the kidneys. The right kidney weighed 95 Gm. and the left kidney weighed 130 Gm. There was a wedge-shaped scar in the right kidney typical of a healed infarct.

Microsections of the lungs demonstrated a diffuse pulmonary hemosiderosis with hemosiderin-laden macrophages filling alveoli, alveolar walls, and interstitial spaces. Red blood cells as well as hemosiderin granules filled the alveoli. There was no apparent destruction of elastic tissue. There was a diffuse acute arteritis of medium-sized arteries of the lung with round cell infiltration of the vascular and perivascular tissue. The alveoli of the lung bases were filled with serous fluid. There was marked proliferation of the fibroelastic tissue of the endocardium in areas of the left ventricle and diffuse infiltration of myocardium of the left ventricle with connective tissue. Acute necrotizing vasculitis was noted in pulmonary veins and medium-sized arteries of the lungs, pancreas, kidneys, and spleen. There was no evidence of glomerulonephritis but a healed renal infarct was present in the right kidney.

Discussion. Approximately 100 cases of idiopathic pulmonary hemosiderosis (IPH) have been reported in the world literature since the first pathologic description was made by Virchow[1] in 1851. The first clinical description was made by Ceelen[2] in 1931, and Waldenstrom[3] in 1944 correlated the clinical course with pathologic findings. There have been excellent reviews in the literature by Wyllie[4] in 194 , Boyd[5] in 1959, and Bronson[6] in 1960.

IPH occurs most frequently in infancy and early childhood but may be seen in the young adult. The symptoms are those of diffuse bleeding into the lung which may be massive or incipient. In the event of massive bleeding, death ensues rapidly with the patient "drowning in his own blood." The more usual course is intermittent bleeding into the alveolar spaces and interstitial tissues

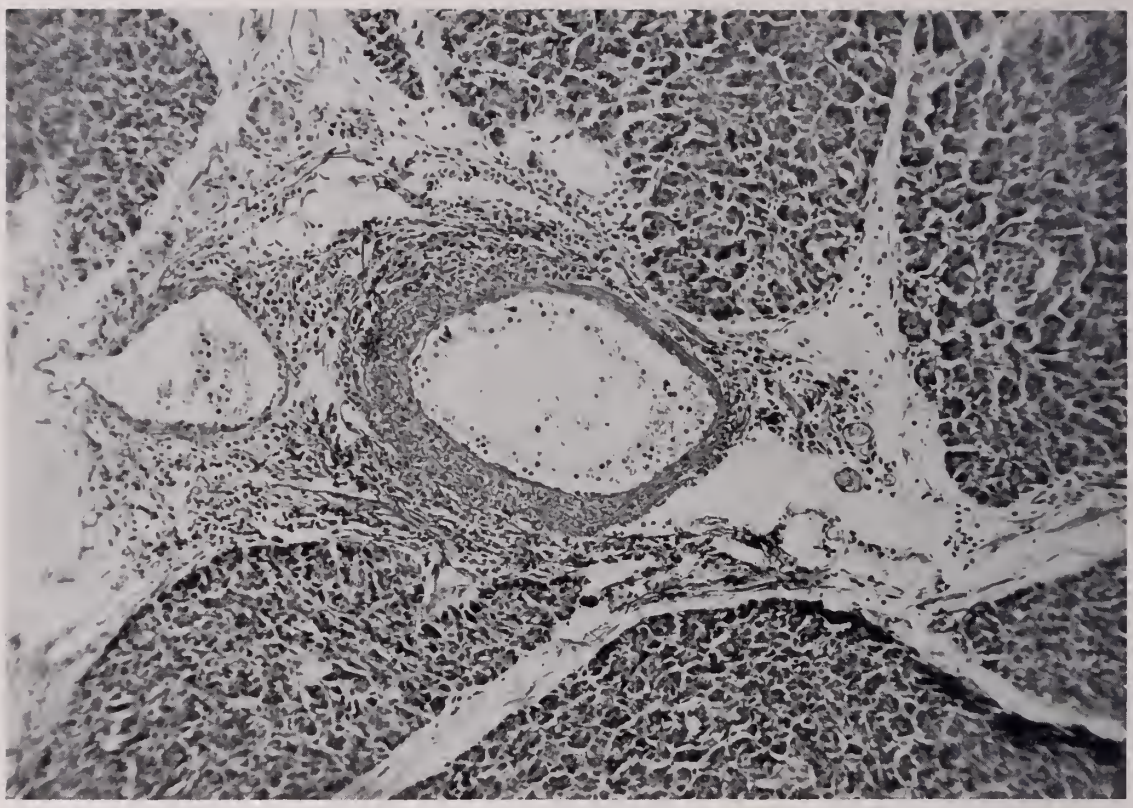

Fig. 2—Microsection (120 X) of the pancreas showing round cell infiltration of the wall and adjacent tissue of a medium-sized artery.

throughout the lungs. The patient describes a tightness of the chest with progressive shortness of breath, cough, and hemoptysis. The physical findings are: pallor, intermittent low-grade fever, tachycardia, and perhaps minimal consolidation with or without fine crepitant râles. One is frequently surprised on viewing the chest roentgenogram to find extensive infiltrations of an irregular mottling or "cotton ball" apperance. The infiltrates change rather rapidly with clearing or migration to other portions of the lung. In the chronic phase pulmonary fibrosis appears with a reticular interstitial scarring and the hilar node enlargement.

The laboratory findings are those of intermittent secondary anemia, normal or decrease in the serum iron, hyperplasia of the red blood cell elements of the bone marrow, and increased reticulocytes in the peripheral blood. Icterus may follow extensive bleeding but is not usually seen. If the sputum is not grossly bloody, it will frequently contain macrophages laden with hemosiderin. Fasting gastric aspiration likewise contains hemosiderin. The finding of hemosiderin-laden macrophages is one of the most useful tools in diagnosis, but more certain is the biopsy of the lung by open thoracotomy or by needle aspiration.

The pathologic findings are those of diffuse bleeding throughout all tissues of the lung. In recent hemorrhage there is massive infiltration of red blood cells in the alveoli and interstitial spaces. With conversion of hemoglobin to hemosiderin the granules of hemosiderin pack the air spaces, connective tissue, and hilar lymph nodes. The granules lie free or are engulfed by macrophages and epithelial cells. Progressive proliferation of interstitial connective tissue, fragmentation, and dissolution of elastic tissue of the lung are noted in the chronic stage.

Death may occur suddenly at the onset of the illness due to massive pulmonary bleeding or may be delayed several years before the fatal hemorrhage occurs. A few survive beyond this stage to develop pulmonary fibrosis and die of cor pulmonale or pneumonia. More recently there have been reported patients

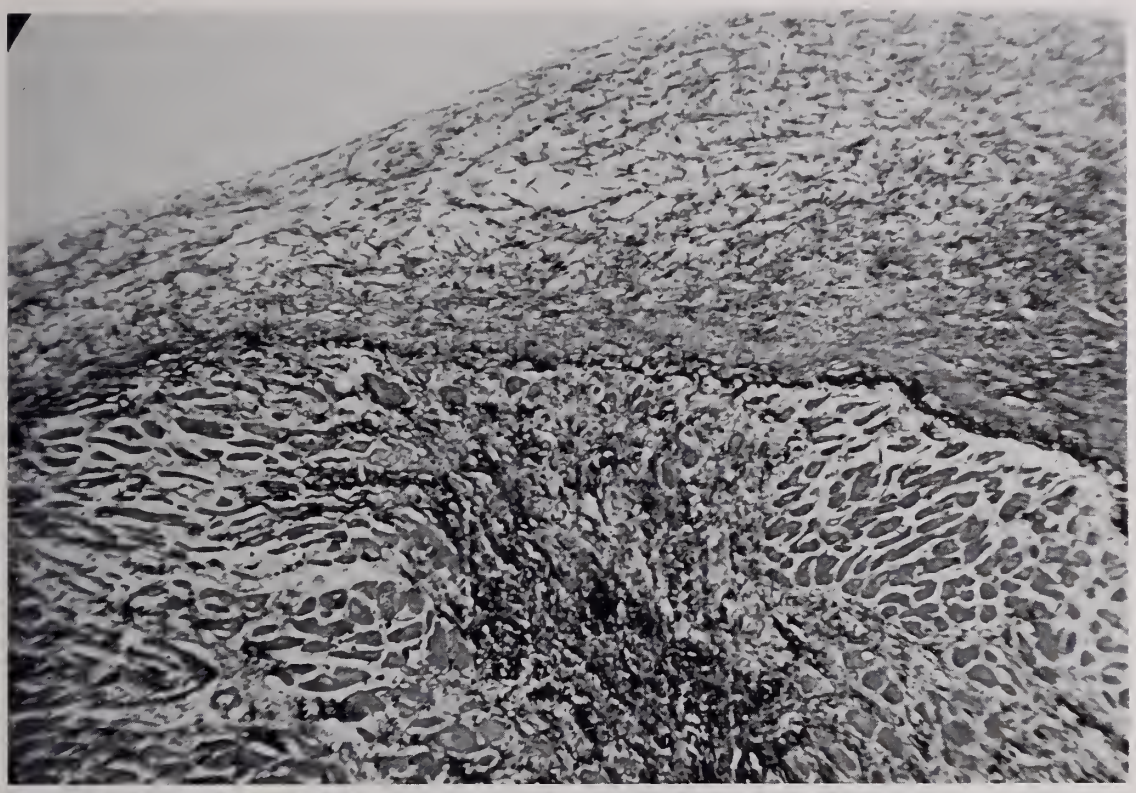

Fig. 3—Micrasectian (120 X) af the left ventricle of the heart shawing a greatly thickened endocardium and dense connective tissue scarring of the myocardium.

who survive with continuing intermittent mild bleeding or even apparent permanent remission. In the past diagnosis usually was made at autopsy, but with increasing awareness of clinical symptoms the diagnosis will be made more frequently in live patients.

Treatment has been unsatisfactory in most cases. General supportive care with iron, blood transfusion, oxygen, and digitalis is instituted as indicated. Steiner[7] advocates splenectomy, but the results have not offered sufficient benefit to justify the operation, whereas, ACTH and adrenal corticosteroids have been more promising with apparent remission in 8 of 17 cases reported.[5,8-20] In 1957 we reported the case of a 16-year-old boy who had a remission after treatment with cortisone.[8] He experienced a relapse of pulmonary bleeding in 1959 which subsided promptly when treated with prednisolone. To date he has remained asymptomatic and fully active.

The etiology, of course, is unknown. There have been numerous theories to explain this unusual phenomenon, two of which have offered plausible explanation. McLetchie[21] in 1949 suggested that defective vasomotor control of the pulmonary vessels permitted massive capillary dilatation and diapedesis of red blood cells into the lung tissue. Steiner[7] in 1954 introduced the concept of autoimmunization, i.e., the alteration of the permeability of lung capillaries by the antigen antibody reaction in an "autosensitized person." The significance of the ingested antigen was demonstrated by Heiner and his associates.[22] Heiner observed four children with IPH who had multiple precipitins to cow's milk. Pulmonary bleeding ceased when cow's milk was evaporated or removed from the diet and recurred when cow's milk was returned to the diet. He studied the serum of the present patient and found significant precipitins to wheat gliadin and suggestive precipitins to milk protein.

Cambell[16] in 1959 presented a case report of a 14-year-old boy who had a course identical to ours, with a seven-year illness of pulmonary hemosiderosis, renal infarction, myocardial fibrosis, and death due to heart failure. Acute necrotizing arteritis was noted in

the lungs. Splenectomy offered six months reprieve but cortisone was of no benefit.

Acute vasculitis is not a feature of IPH and has been reported in only two previous cases. Anspach[23] in 1939 described acute arteritis in the lung of a 9-year-old boy and Cambell in 1959 as described above. The possibility that the vasculitis observed by Cambell and by the author may have been related to steroid therapy is to be considered in view of the observation by Kemper[24] in 1957 and Johnson[25] in 1959 that there is an increase in vasculitis in rheumatoid arthritic patients treated with steroids.

IPH associated with glomerulonephritis, "Goodposture's syndrome," has been reported in 25 cases in the literature.[17,26,27,28] In 1919 Goodposture[29] described an 18-year-old man who had acute pulmonary hemorrhage, necrotizing alveolitis, glomerulonephritis, and acute arteritis of the spleen and intestine. Acute arteritis was described in 8 of the 25 cases.

Summary. An unusual case report of idiopathic pulmonary hemosiderosis (IPH) is presented in a boy who became ill at the age of 6 years with recurrent anemia secondary to pulmonary bleeding and died at the age of 12 years with irreversible heart failure of one year's duration. The pulmonary bleeding subsided for about four months while he was receiving prednisolone. Significant precipitins to cow's milk were found in his serum. The autopsy findings were those of diffuse pulmonary hemosiderosis, endomyocardial fibroelastosis, and diffuse acute vasculitis. This triad was observed in only one other child (Cambell[16]) and therefore is worthy of recording in detail.

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The author wishes to thank the following of the Mayo Clinic, Rochester, Minn.: W. H. Weidman, M.D., for clinical progress reports; and J. W. Kernohan, M.D., and Betty Thomas, M.D., for the autopsy report and duplicate sections of tissue used in this case presentation.

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Surgical Resection and Grafting of Traumatic Thoracic Aortic Aneurysm

By WILLIAM M. STOLL, M. D., Green Bay, Wisconsin

■ IN 1958, L. F. Parmley and associates[1] reported a series of 275 cases of aortic injury. In their series 13.8 per cent of the patients were alive at the time of hospitalization, and only 2 patients of the entire series survived to the chronic stage, whereby resection of the false aneurysm was carried out. Thus, the incidence of survival from a traumatically ruptured aorta is extremely low, less than 1 per cent.

The following case represents one of these rare but fortunate individuals who survived.

Case Report. A 41-year-old white woman, weighing 190 lb., was struck by an automobile while crossing a downtown street; she was dragged approximately 60 feet by the vehicle. She sustained fractures to the left upper extremity and was in shock when admitted to the hospital. Subsequent examination revealed a hemothorax on the left side and a widened mediastinum. Conservative therapy was carried out, including placing the left upper extremity in a cast. X-ray films of the chest revealed a thoracic aortic aneurysm distal to the aortic arch area.

The patient was seen in consultation by the author 10 weeks following the injury. A venous aortogram revealed a 12 cm. saccular aneurysm originating just distal to the left subclavian artery.

Surgical resection of a large saccular, false aneurysm of the proximal descending thoracic aorta, originating 1 cm. distal to the left subclavian artery, was performed. The aorta was isolated proximally and distally to the aneurysm. The patient was placed on partial left heart bypass, left atrial to left common femoral artery; and the aorta proximal and distal to the large aneurysm was clamped. The bypass flow rate varied between 20 and 40 ml. per minute per Kg. of body weight, depending upon the systemic blood pressure in the right arm. Partial bypass was maintained for 61 minutes while the aneurysm was resected and a 5 cm. length of Dacron graft was inserted. Upon opening the aneurysm it was found that the aorta had been completely transected with the ends 2 cm. apart. The false aneurysm was composed of the adventitia and overlying pleura.

The patient made an uneventful recovery and was discharged 16 days postoperatively, her left arm still in a cast. She subsequently had open reduction of her arm fracture.

Discussion. Review of the literature by Garamella and associates[2] has revealed approximately 92 cases of surgical resection of a traumatic thoracic aortic aneurysm. In a series of 179 thoracic aortic aneurysms, DeBakey and his associates[3] reported 3 of the traumatic etiology in the aortic arch and 9 in the descending aorta. Parmley and associates[1] reported a series of 275 cases of aortic rupture, 156 as a result of automobile accidents.

The high incidence of rupture occurring at the aortic isthmus is explained on the basis of a relatively mobile segment of aorta between two relatively fixed points, the subclavian artery above and the ligamentum arteriosus and first intercostals below.

In patients initially surviving the aortic injury a mediastinal hematoma develops, and the patient may progress rapidly or slowly to death. In less than 1 per cent of cases a false aneurysm develops, and survival may continue for months or years.

The need for early recognition is evident. The usual lack of external signs of chest injury and the widened mediastinum shown on chest x-ray films should suggest the diagnosis. When one is presented with a mediastinal hematoma, the role of diagnostic

angiography, thoracic exploration, and consideration of aortotomy are features in the management of this urgent problem.

Summary. The case of a 41-year-old woman with a traumatic thoracic aortic aneurysm is presented. She developed the aneurysm after being struck by an automobile. The proximal descending thoracic aorta was completely transected at the time of the accident with the subsequent formation of a false saccular aneurysm. Ten weeks after the injury the aneurysm was resected, utilizing left atrial to left common femoral bypass, and a Dacron graft was inserted. Less than 1 per cent of patients who have a traumatically ruptured thoracic aorta survive and subsequently develop an aneurysm.

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ESSAY CONTEST

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize Essay of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Recent Advances in the Control of Respiratory Virus Diseases, Including the Exanthemata." The essay must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submittted by December 11, 1964.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, R. I. 02903.

SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1964–December 31, 1964

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION MADISON, WISCONSIN 53703

Location	*Date*	*Location*	*Date*
Ashland	July 29 and 30	Eau Claire	September 30 and Oct. 1
Manitowoc	August 5 and 6	La Crosse	October 14 and 15
Stevens Point	August 19	Racine	October 21 and 22
Marinette	September 9	Chippewa Falls	October 28 and 29
Superior	September 17	Rhinelander	November 12 and 13
Kenosha	September 23 and 24	Sheboygan	November 17 and 18

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison, Wisconsin 53703.

An epidemic takes its toll and runs its course!

INFECTIOUS HEPATITIS

AN OUTBREAK IN A RURAL WISCONSIN SCHOOL DISTRICT

EPIDEMIOLOGY

By REX E. GRABER, M. D., M. P. H.
Chippewa Falls, Wisconsin

■ WHEN INFECTIOUS hepatitis was reported in an adult resident of Birchwood, Wis. in July 1963, the number 50 was attached to his case. His illness became the fiftieth case of a series related to a school outbreak which reached a peak during the second week of the preceding February. Birchwood, population 433, is an isolated village with no physicians. The public school has an enrollment of 270 in 12 grades. The combined population of Birchwood and surrounding towns in which cases occurred is 960. During Wisconsin's summer resort season, this population is increased many times over by vacationers and fishermen.

In the nation, hepatitis ranks third in the number of cases of communicable diseases reported to the Public Health Service, being exceeded only by measles and streptococcal infections.[1] Reported cases of viral hepatitis in Wisconsin annually have ranged from 251 to 403 cases during the last four years. This is at an average annual incidence rate of approximately 7 per 100,000 population, as compared with the national average of 29 per 100,000.[2] Although most of the Wisconsin cases have been sporadic in incidence, Preizler,[3] in a review of recent patterns of occurrence, cites three previous outbreaks in small Wisconsin communities, with the number of cases ranging, respectively, 24, 30 and 28.

The Outbreak. In a study of the Birchwood outbreak, a history was obtained on all reported cases. These are listed in Table 1 and numbered consecutively by date of onset. The epidemic curve is shown in Figure 1. Case 1 (not shown in Fig. 1) and Case 3 are wife and husband. Obviously the one infected the other, but otherwise no history could be elicited which would link either of these early cases, nor Case 2 etiologically to subsequent infections, although the temporal relationship is compatible.

As seen in Figure 1, the primary wave of incidence extends from January 25 to February 19 and shows a blunt peak about February 11. During this time 29 cases were reported. Of these, 23 were in school children, evenly distributed throughout the 12 grades. Two of the six adults were teachers in the school; the other four were parents of school children ill at the same time. (For purposes of this report an adult is a person who is 19 years or older.)

A secondary wave of incidence of lesser amplitude covers the first three weeks in March. Seven cases appeared subsequently, the first April 4, the next two about the middle of April, and two more the latter half of May. These were followed in four weeks by Case 49 and in five and one-half weeks by Case 50. The surging and grouping of cases are suggestive of incubation periods slightly exceeding 30 days.

In Table 1, numbers in parenthesis in the fifth column are assigned sequentially to identify eight families in which more than one case occurred. These are also projected to Figure 1 where intervals of time between case onsets within these families may be viewed graphically. In families (3) and (7), three generations of the disease were observed. Intervals again suggest incubation periods approximating 30 days.

Gamma globulin distributed by the state was in short supply early in 1963, and the expense of globulin from a commercial source was a deterrent to its free use as a preventive measure. Furthermore, medical and hospital facilities were available only after the inconvenience of 20 miles of travel. These circumstances were mentioned repeatedly in case histories and explain why rela-

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The outbreak was investigated by the author and reported concurrently as the events unfolded to the Bureau of Communicable Diseases, Wisconsin State Board of Health.

Doctor Graber is District 7 Health Officer for the State Board of Health, with offices at 718 West Clairemont Avenue, Eau Claire. He is also certified by the American Board of Preventive Medicine.

TABLE 1—*Reported Cases of Infectious Hepatitis—Birchwood, Wis., 1963*

Case No.	Initials	Sex	Age	Family Group	Date of Onset	Days Absent From School
1	JH	F	20	(1)	12-11-62	
2	FM	M	19		1- 7-63	
3	MH	M	25	(1)	1-15-63	
4	CC	F	9	(2)	1-25-63	10
5	MF	F	44	(3)	1-27-63	
6	EB	F	53		1-28-63	27
7	MR	F	33	(4)	2- 2-63	
8	GG	M	32		2- 3-63	18
9	JR	M	38	(4)	2- 4-63	
10	SL	M	10		2- 4-63	14
11	RP	F	10		2- 4-63	19
12	EO	M	12		2- 4-63	19
13	LC	M	16		2- 6-63	19
14	JC	F	7	(5)	2- 7-63	11
15	DM	M	15		2- 7-63	12
16	RG	M	9		2- 7-63	18
17	JG	M	35	(5)	2- 8-63	
18	GJ	M	6	(6)	2- 8-63	10
19	DR	M	6	(4)	2- 8-63	10
20	BK	F	7		2-11-63	14
21	SJ	F	7	(6)	2-11-63	9
22	DS	F	10	(7)	2-11-63	15
23	DG	F	10	(5)	2-11-63	8
24	SK	F	13		2-11-63	14
25	RC	M	16		2-11-63	10
26	SS	F	11	(8)	2-12-63	8
27	RS	F	9	(7)	2-12-63	8
28	CV	M	13		2-12-63	7
29	AG	F	15		2-12-63	11
30	GH	M	11		2-15-63	11
31	JV	M	13		2-15-63	24
32	KB	F	10		2-19-63	13
33	JS	F	18	(8)	2-28-63	18
34	BK	M	72		3- 2-63	
35	DV	M	8		3- 4-63	14
36	NF	M	10		3- 8-63	31
37	CV	F	47		3-13-63	
38	RG	M	15		3-15-63	11
39	RF	F	21	(9)	3-15-63	
40	EF, Jr.	M	18	(3)	3-15-63	
41	AS	F	36	(4)	3-19-63	
42	BS	M	14	(4)	3-21-63	18
43	MF	F	19	(5)	3-31-63	
44	RF	M	15	(5)	4- 4-63	16
45	PS	F	15	(4)	4-15-63	14
46	LF	F	17	(5)	4-19-63	
47	FK	M	13		5-20-63	15
48	AE	M	31		5-22-63	
49	GS	M	33		6-18-63	
50	JJ	M	57		7- 1-63	

TABLE 2—*Summary of Cases Classified by Age Groups and Sex*

Age Group (years)	Number of Cases			Per Cent
	Male	Female	Total	
6- 9	4	5	9	18
10-13	7	6	13	26
14-18	7	4	11	22
19+	9	8	17	34
All ages	27	23	50	100

tively few of the known contacts received prophylactic treatment. In view of the well-known efficacy of gamma globulin in aborting or suppressing infections after exposure,[4] it appears likely that the lack of its free availability contributed to an increased incidence of secondary cases.

In spite of this, the outbreak was well contained with respect to geographical area and segment of population affected. More than 90 per cent of the cases resided within the Birchwood school district, and 84 per cent

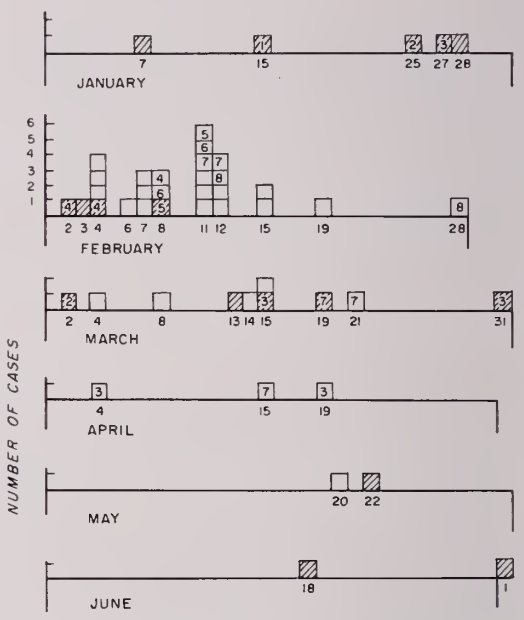

Fig. 1—Infectious hepatitis cases by date of onset, Birchwood area, January–July 1963. Numbers in squares identify families with multiple incidence.

were in school children and their household contacts. The list includes 33 children and 17 adults, 23 are female and 27 male. The number of males and females in each of four age groups is shown in Table 2.

Diagnosis. In epidemic hepatitis the diagnosis presents little difficulty, except perhaps in anicteric cases. The disease is identified by its characteristics as an acute infection with fever, loss of appetite, nausea, abdominal discomfort, varying degrees of prostration, followed by varying intensities of jaundice with dark urine and light stools. In the Birchwood cases an enlarged and tender liver was an inconstant finding.

Not all of the patients were seen by a physician. Reports by parents of school children ill with jaundice were accepted as hepatitis. Many other cases of mild illness without jaundice were reported simultaneously in siblings. Although some of these were undoubtedly anicteric hepatitis infections, they were not included in this report. A physician's diagnosis of anicteric hepatitis in two adults was based on the epidemiological history and laboratory findings of impaired liver function and hyperbilirubinemia.

In its follow-up and surveillance program of viral hepatitis, the Wisconsin State Board of Health enumerates all cases reported, but routinely records individual case records with historical data on adults only. This policy is based on the assumption that adult cases will include the preponderance of cases of serum hepatitis and will serve as the most sensitive indicators of epidemics ascribed to a common source, particularly those due to raw oysters and clams. Accordingly, a routine history was obtained on the adult cases, covering six months before onset, specifically with reference to transfusions, parenteral inoculations, blood tests, skin tests, narcotic addiction, dental work, other surgery, and the like. In all cases such history was negative. Thus the remote possibility of serum hepatitis among the victims was ruled out. No attempt was made to isolate the infective agent.

Clinical Course. As expected, milder symptoms and a more benign course were noted in the younger age groups. Interestingly, no case in a child under 6 years of age came to diagnosis. Absenteeism from school by 32 children and 2 teachers amounted to a total of 494 days; the average number of days per person was 15. Thus, a protracted course of illness was noted, as compared with that of other common infections. No fatalities occurred, and no serious complications nor sequelae were noted during the period of a year following the peak of incidence.

Source and Transmission. The primary source of infection and the method of transmission have not been precisely determined. Because of the explosive character of the outbreak, it is evident that a large number of susceptible individuals, mostly children, but including some adults, were exposed to infection about the same time. Relating this time to the peak of the primary wave of incidence places it at or near the reopening of school on January 2 after a two-week Christmas vacation.

In seeking to determine where and how infections passed from person to person, several other environmental factors were considered; particularly those possibly related to a fecal-oral spread. It was noted that a school lunch program operated daily, with food served in a cafeteria in the basement of the main building. A sanitary survey of the physical facilities on Feb. 11, 1963, disclosed that handwashing facilities were not present in the basement. However, a history of illness in the food handlers, temporally related to the outbreak, could not be elicited. A laboratory test of the school's water supply drawn on February 11 indicated bacteriological safety. Since attendance records of the cafeteria lunches were not kept, no attempt was made to correlate illnesses with cafeteria patronage.

With no municipal water and sewer systems, waste disposal in the village has always been unsatisfactory. Many of the residents maintain pit privies. Others have installed septic tanks and dry wells; the latter function inadequately due to unsuitable subsoil formations. Surface runoff of septic tank effluent is often in evidence. Conditions such as these prevailed during the fall of 1962 and into the winter. As a striking example, a stream of septic tank effluent ran intermittently from the rear of a laundromat establishment, constituting in effect an open sewer for a distance of several hundred feet in a ditch along the side of a street. Across the street is a large open area used by the school children as a playground. Children have been seen retrieving a thrown or batted ball from the ditch and wiping off the moisture on their clothing.

"Everyone in town uses the laundromat," says the local health officer. Hence, any attempt to correlate infections with patronage of the laundromat would be futile. Washing the family's garments in an automated communal contrivance seems to be one of the newer proclivities which draw mankind into a snugger togetherness in a tighter world. Whether some housewives take home more pathogens in their laundry than they bring with them is a problem beyond the scope of this report.

In the case histories of the adults, other than those of multiple incidence in families, as a rule, the patient was unable to identify his infecting contact. One exception is colorful and interesting. A 31-year-old white man had gone fishing with a friend, a 33-year-old white man, on May 15, 1963. They had shared the same thermos cup to drink coffee. The first man became Case 48 with initial symptoms on May 22, 1963. The second man became Case 49 with onset of symptoms on June 18, 1963. The colorful part of this goes beyond the jaundice. The two fishermen have demonstrated to the world the existence of infectivity a week before the onset of initial

symptoms and a pin-pointed incubation period of 34 days.

It was learned by chance that an act of trained animals had been staged in the school gymnasium on Nov. 16, 1962. The animals performed their tricks on a large canvas mat belonging to the show. The act was booked out of Chicago, Ill. Two monkeys appeared in the show, which suggested the possibility of a simian source of the hepatitis outbreak, with transmission to the audience through contaminated aerosols from the canvas mat or the animals, if not by direct contact. In recent years a hepatitis carrier state in chimpanzees has accounted for at least 13 human outbreaks on the basis of epidemiological evidence.[5] Numerous other sporadic cases have been reported in persons closely associated with the care of young recently imported chimpanzees and other subhuman primates. However, the Chicago monkeys appear to be innocent as instigators of the Birchwood outbreak because of the absence of a compatible incubation period, as well as the absence of epidemiological evidence of similar infections at other locations where the act has played.

In ruling out a water-borne source of infection, it was noted that coliform organisms were not detected in the school's water supply on February 11. It is inconceivable that surface or subsurface contamination could have reached a sufficient number of wells simultaneously throughout the village and surrounding countryside to have resulted in this explosive outbreak. It is interesting that a study by Nichols[6] in October 1963 also yields negative evidence on impure water supplies. In a sample of 26 of the estimated 120 individual water supply sources located within the village limits, Nichols was able to detect a hazard from bacteria in only one. The sample included all of the wells supplying the residences in which the 15 cases occurred in the village. None of the wells showed more than minute traces of detergent. On October 22, water was observed flowing down the roadside drainage ditch previously mentioned, 200 feet below a septic tank serving the laundromat which was located on higher ground. A sample of this ditch water yielded a strongly positive test for detergent.

Summary. The primary source of the outbreak could not be positively identified. Quite likely it was in a person carrying an inapparent or unrecognized infection. A fortuitous factor in transmission was present during the Christmas holiday season, a time for increased familial and communal activities and contacts. This brought the infected source to the environment. Freezing weather probably contributed to malfunction of overloaded private sewage disposal facilities, resulting in fecal contamination of extensive ground areas in the village.

Inexorably, the stage was set for massive transmission when the school reconvened on Jan. 2, 1963, following the holiday season. The time relation is compatible with the incubation period of the disease. A salient epidemiologic feature further bears this out in that 18 of the 29 victims of the primary wave of incidence resided outside the village. With the reopening of the school they had returned to the village environment. Here the pressure of transmission of the infective agent was operating through open channels of personal contacts to produce this unusually severe outbreak which crested five to six weeks later.

Life in the village was not untouched by this community affliction, especially during the first two months. School athletic and forensic events were postponed. Self-appointed committees helped secure regular servicing of the laundry's septic tanks, watching for overflow day and night. People developed a habit of wiping off their door handles after receiving visitors. Fortunately no adverse effect was noted the ensuing season in the resort business, one of the community's sustaining industries. Finally, the village board has progressed fruitfully in plans for a municipal sewerage system.

ACKNOWLEDGMENT: The assistance and cooperation of Mr. James DiUlio, Birchwood School administrator, and the Rice Lake physicians in obtaining case histories is gratefully acknowledged.

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CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: PETER F. SCHATZKI, M. D.
Milwaukee, Wisconsin

Case Presentation.* A 54-year-old white man was first admitted to the hospital in May 1963 with an eight months history of malaise, dependent edema, dyspnea, orthopnea and paroxysmal nocturnal dyspnea. This was accompanied by a 20-lb. weight loss. During the preceding winter the patient had also noted some pain, whiteness and numbness of his finger tips. Five months after onset and three months before admission to this hospital he was admitted to another hospital where increased skin pigmentation and deficiency of hair growth in the beard area, axilla, abdomen, and chest were noted. Laboratory work at this time revealed low 17-ketosteroids which rose with ACTH stimulation.

Physical examination on admission revealed a well-developed, well-nourished man who appeared chronically ill. The skin over the dorsa of the hands and the extremities appeared thickened and shiny. His pulse rate was 72, blood pressure 125/80 mm. Hg. and respiratory rate 16. The breasts showed gynecomastia. There was a grade 3 systolic murmur over the aortic area.

Laboratory studies on admission revealed a hemoglobin level of 9.1 Gm. per 100 ml., red blood cells 3,700,000 per cu. mm., and erythrocyte sedimentation rate 16 mm. per hour. The serum proteins were albumin 3.3 and globulin 3.7 Gm. per 100 ml. Protein electrophoresis was normal. The serum iron was 20μg. with iron binding capacity of 365 μg. Laboratory studies were otherwise not remarkable.

The patient's occupation was unknown. The patient always had little facial hair and no axillary, chest or suprapubic hair growth. He was the father of seven children.

The patient left the hospital shortly after admission. He was admitted elsewhere three months later where studies included a hemoglobin level of 8.1 Gm. per 100 ml., erythrocyte sedimentation rate 54 mm. per hour, and a blood urea nitrogen of 40 mg. per 100 ml. Small intestinal x-ray examination revealed a malabsorption pattern with segmentation and loculation.

One day before his final admission in September, he had sudden vomiting followed by unconsciousness. Respirations were 40 per minute, and blood pressure 260/120 mm. Hg. The patient was unresponsive, did not move his arms or legs, and had bilateral Babinski reflexes. The white blood cell count was 25,000 per cu. mm., with 28 nonsegmented and 55 segmented neutrophils, 9 lymphocytes and 8 monocytes; and the hemoglobin level was 11.8 Gm. per 100 ml. The urine was positive for sugar and 2+ albumin with many hyaline and waxy casts. The blood sugar was 278 mg. per 100 ml., carbon dioxide content 19.5 mEq./l., and blood urea nitrogen 43 mg. per 100 ml. The spinal fluid showed opening pressure 220 mm. water, 40 mg. protein, 1 white blood cell, 3+ globulin, 177 mg. sugar, gold sol curve 5555433211, serology negative. The patient developed several seizures beginning in both feet and lasting several minutes. He died five days after admission without regaining consciousness. The blood urea nitrogen had risen terminally to 116 mg. per 100 ml.

Clinical Discussion. *Dr. Norbert Enzer:* The challenge in this case is not as great in the area of diagnosis as in the precise explanation of the various manifestations, especially those appearing in the terminal stage of the illness.

A diagnosis of scleroderma in this case, or to use the better and more modern term, systemic sclerosis, leaves little room for difference of opinion. While there is lacking in the available record some interesting and

* From Mount Sinai Hospital.

supportive information (such as biopsy of the skin, x-ray film of the chest, and determination of the rheumatoid factor) the manifestation in the skin, the relatively short history, the obvious severity of the condition, evidence of cardiac pathology, loss of weight, absence of evidence of systemic lupus erythematosus, thyroid disease, infection, and especially malignant tumor together makes systemic sclerosis the logical diagnosis.

Since this disorder has been well documented, the behavior of this patient provides stimulus for seeking and understanding the reasons for certain features.

A heart condition was recognized early in the illness and attributed to aortic and mitral disease and was responsible for congestive failure, with edema. A history of rheumatic fever or any systemic infection is not available. The heart pathology probably was not due to rheumatic fever and also not likely due to arteriosclerosis. The description of the murmurs and the absence of cardiomegaly point to a valve pathology of more recent origin.

It may be suggested therefore that already at that time there was an advanced stage of systemic sclerosis affecting the myocardium and valvular endocardium. The latter condition would explain the murmur and would be in the form of sclerosis of the endocardium and valves with resulting deformity and functional impairment. Also since the myocardium is characteristically affected by atrophy of fibers and replacement by a characteristic scarring fibrosis—usually acellular—this was probably largely responsible for functional failure. The myocardial disorder in these cases is generally independent of coronary artery disease, although conventional sclerosis of the coronary arteries may be an additive contributing factor to the damage done the myocardium by the disease.

Cardiac decompensation will be influenced adversely if there is also involvement of the lungs, which occurs in a very high percentage of the cases. The special significance of the cardiac involvement in this case is that it apparently preceded the skin manifestations. This has been recorded; so there may be visceral sclerosis without scleroderma just as in systemic lupus erythematosus there may be renal and cardiac disorders without clinical evidence of dermal manifestation. The vicarious and capricious behavior of the group of conditions known as the collagen disorders is well known and contributes to the difficulties in early diagnosis. Probably not until we have available screening procedures to detect background—constitutional, inborn and/or genetic indications, or more specific immunochemical identifications—will we be able to cope with some hope for success with these related conditions.

In this patient the early presentation of involvement of the hands, including the history of Raynaud's phenomenon, justifies the elimination from consideration of the benign condition, scleredema. Scleredema might not be related to the relentless disease scleroderma, just as discoid lupus sometimes precedes and may not be related to systemic lupus erythematosus. In this manner also there are certain common denominators with rheumatoid arthritis. I suspect also that cases with heart, lung, or renal disorders—but without dermal manifestations—have been overlooked as belonging to the group, systemic sclerosis, and variously classified as chronic fibrous myocarditis, postcoronary myocardial fibrosis, idiopathic pericarditis with myocardial fibrosis, pneumonitis with fibrosis, malignant hypertension, and malignant nephrosclerosis. When the disorder affects the gastrointestinal tract, especially the esophagus, the diagnosis is easier to make.

In our patient the renal condition, which was a rapid and fulminating element, has been considered by some investigators as a type (anatomically) characteristic for systemic sclerosis. How often this occurs is not clear and also how often the same pattern of vascular and glomerular effects are found in other conditions likewise is not clear. At any rate, from a clinical point of view, the manifestation of renal progression is more often manifested by retention of protein and elevated blood pressure than by proteinuria and hematuria.

Cerebral involvement in most instances is due to the effects of uremia and hypertension. The precise and same type of vascular pathology I believe has not been demonstrated, yet multiple foci of cerebral ischemia, as seen in malignant hypertension, may occur and probably did in this case. In this general group of collagen disorders the vascular pathology is an effect, since it varies in pattern and visceral distribution. I am not sure that the changes in the vessels of the

fingers causing the Raynaud's disorder are the same as in the visceral vessels. I think that a massive cerebral vascular accident did not occur here. It is interesting to note how often the autopsy reveals only cerebral edema and focal ischemia in patients with clinical manifestations of specific anatomic localizations, particularly in those with renal failure.

Finally in this patient the condition of thrombotic thrombocytopenia and hemolytic anemia with associated angiitis should be mentioned as a possible cause of the gastrointestinal bleeding and the cerebral manifestations. It is possible that multiple acellular or bland thrombi precipitated in arterioles or even terminal arteries, not necessarily because of a condition of the vessel walls but because of a chemical change in the moiety of circulating proteins. It seems to me this occurs in disorders in which there are demonstrably severe rearrangements of the proteins, e.g., autoimmune disorders, systemic lupus erythematosus, and malignancy (Hodgkin's disease, myeloma, carcinoma of pancreas, and the like).

In this case mention must be made of the importance of eliminating from differential consideration an unrecognized malignant tumor. From the viewpoint of the clinical record it is not possible to marshal any substantial evidence one way or another.

The manifestations of some less than normal secondary sex characteristics were probably incidental.

My final diagnosis then is systemic sclerosis (scleroderma), with specific involvement of the heart, and involvement of the kidneys, gastrointestinal tract, blood vessels, skin and brain, but these not necessarily as specific except for the gastrointestinal tract and skin. The probabilities are in favor of the nephropathy being type-specific, at least insofar as the general characteristics of collagen disorders go. I believe on a probability basis also that the lungs were involved by this disease.

Pathological Discussion. *Dr. Peter F. Schatzki:* At autopsy the body was fairly well nourished and fairly well developed. The skin was tough, parchment-like, and indurated. There was no free fluid in the body cavities. The heart weighed 440 Gm. and was slightly enlarged. The tricuspid valve was mildly thickened and the mitral valve was moderately thickened. Both ventricles were somewhat dilated. There was a horseshoe kidney weighing 325 Gm. The testes were 3 cm. in length and appeared unremarkable. The brain weighed 1,450 Gm. and appeared unremarkable.

The anatomical findings in this patient were quite widespread. There was severe sclerosis of the kidneys and lungs, with lesser sclerosis of the esophagus, pericardium, mitral and tricuspid valves of the heart, pancreas, periadrenal blood vessels and serous membranes. The sclerosis was manifested generally by an increase of collagen. Inflammatory activity was not noted. The sclerosis in the lungs was a fibrous thickening of the alveolar membranes and blood vessels. The changes in the kidney consisted of marked cortical atrophy, with a marked increase in the fibrous interstitial tissue. There was a normal number of glomeruli, but the capillary walls of the glomeruli were markedly thickened, with a markedly decreased content of red blood cells. There were hyalinized thrombi within some capillaries. Occasional glomeruli revealed actual necrosis with hemorrhage into Bowman's space. Some of the smaller arterioles revealed fibrinoid necrosis whereas others were well preserved. Some proximal tubules revealed various degenerative changes such as hyaline droplet degeneration and necrosis. Most striking were the intralobular arteries which revealed a concentric onion-skin thickening of the intima, with an extreme narrowing of the lumen. There were a few foci of fibrinoid necrosis of the media. The changes in the skin were those of marked collagenous thickening or scleroderma. There were also a few foci of bronchopneumonia, a small focus of necrosis in the prostate, and a small pulmonary embolus. The changes in the brain were confined to the thalami, where there was focal necrosis of small arteries with fibrinoid necrosis of the wall, thrombosis of the lumen, and focal infarcts surrounding the areas of vascular injury. The changes in the testes were those of hypoplasia.

This was a case of extensive sclerosis of multiple organ systems, particularly of the kidneys, or so-called generalized systemic sclerosis. The changes in the kidneys were similar to those of malignant nephrosclerosis and in the absence of a collagenizing disease elsewhere would probably be regarded as characteristic of malignant

Fig. 1—Heart, showing mitral valve. Note thickening of the valve and of the chordae tendinea.

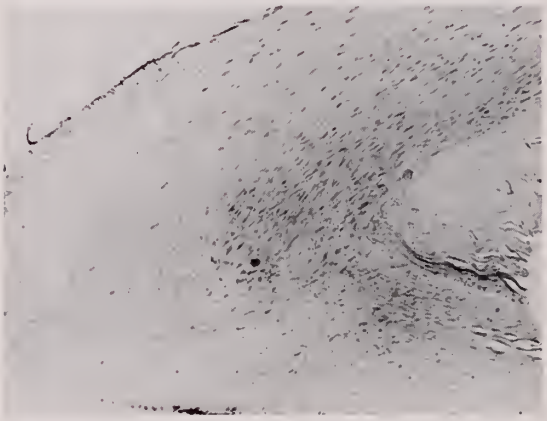

Fig. 2—Mitral valve. Note the dense collagenization.

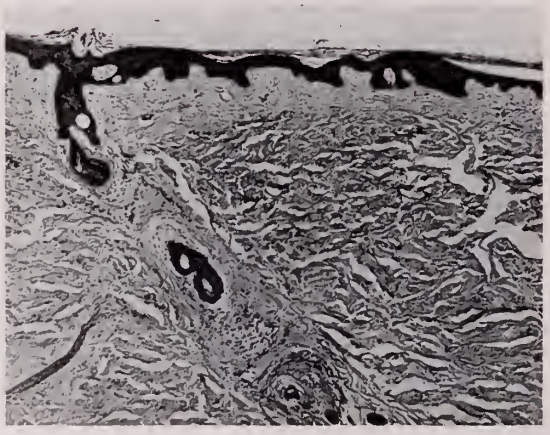

Fig. 3—Skin. There is increased collagen in the dermis, atrophy of the epidermis and atrophy of skin appendages.

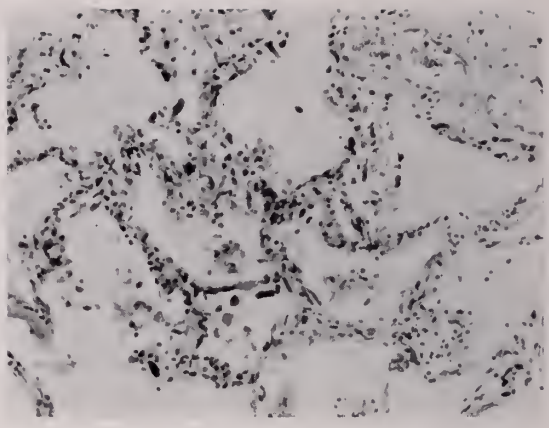

Fig. 4—Lung. Alveolar walls are thickened and collagenized.

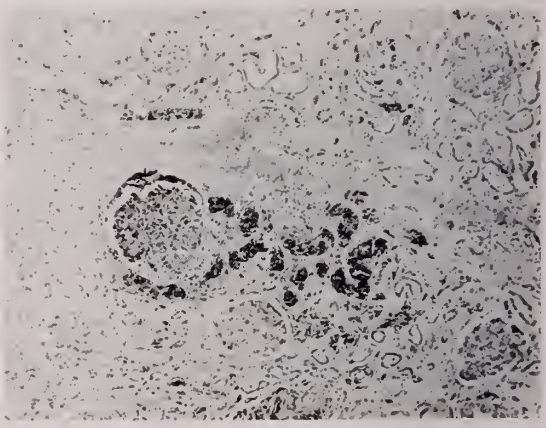

Fig. 5—Kidney. Note the necrotic glomerulus in the center with hemorrhage in its tubules. Superior to the glomerulus is an arteriole with subendothelial fibrous tissue proliferation.

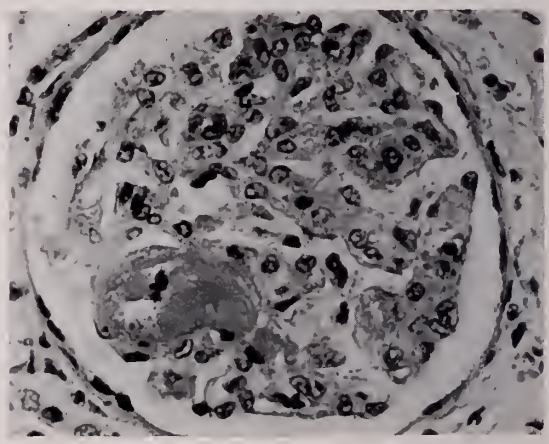

Fig. 6—Kidney. Fibrinoid necrosis of a glomerular segment with collagenous thickening of glomerular capillaries.

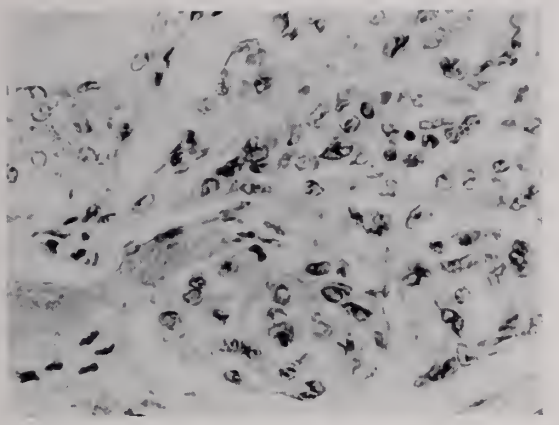

Fig. 7—Kidney. Note the fibrinous thrombus in the arteriole entering the glomerulus.

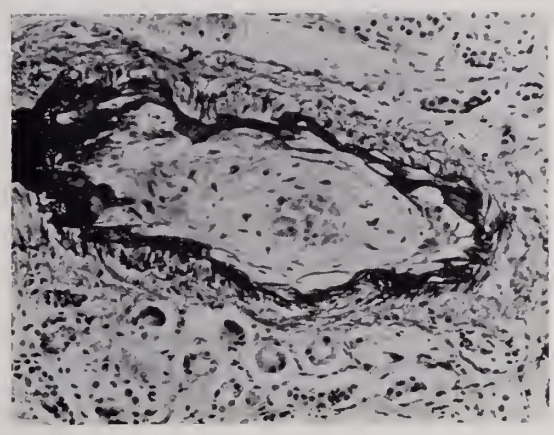

Fig. 9—Kidney artery showing subendothelial fibrous tissue proliferation, separation of fibers and narrowing of the lumen. Elastica stain. 319 X.

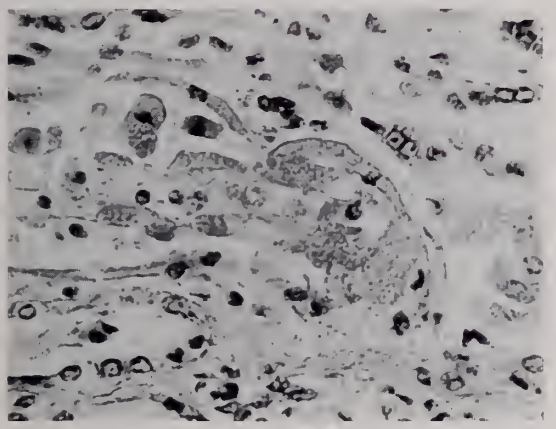

Fig. 8—Kidney showing necrotizing changes in proximal tubules.

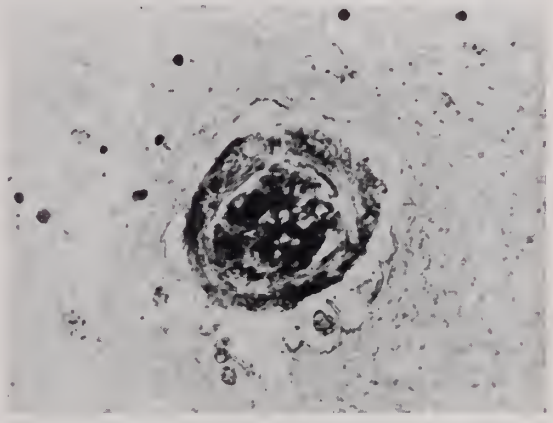

Fig. 10—Brain. Note smudgy necrosis of an arterial wall with thrombosis of the lumen. PTAH. 806 X.

nephrosclerosis. The changes in the brain were unusual. The necrosis of the small vessels was similar to the lesions in the kidneys and was probably a part of the disseminated necrotizing and fibrosing process appearing in this patient. The possibility of a hypertensive encephalopathy secondary to the kidney disease also must be considered, but in view of the characteristic appearance of the small necrotic blood vessels in the thalami, a sclerosing and necrotizing process of the same type as in the body, occurring in the brain, is more likely.

The endocrinologic defects in this patient were also of interest. The testes at autopsy were hypoplastic, but other endocrinic organs were unremarkable. Certainly the siring of seven children tends to rule out Klinefelter's syndrome or other testicular deficiency. Quite possibly the low adrenal function as revealed by the low steroid excretion might have been secondary to the sclerosing disease this patient suffered.

This type of systemic sclerosis, with or without the stigmata of scleroderma, is a well known, although uncommon, entity of undetermined etiology. The disease differs from the usual relatively banal scleroderma confined to the skin both in course and in the usual absence or uncommon occurrence of acrocyanosis in the disseminated form.[1] Our patient proved an exception to this rule since he did in fact have acrocyanosis. The presence of severe kidney disease indistinguishable from malignant nephrosclerosis was striking and has been observed by others.[2] The clinical history of the brain involvement is similar to the episodes of hypertensive encephalopathy described in malignant nephrosclerosis, although it was

believed that the vascular lesions illustrated are of the same etiology as the lesions in the kidney and not secondary to the effects of the hypertension on the brain.

The cause of scleroderma is obscure. A discussion of etiology[3] mentions a number of causes ranging from emotional and psychosomatic illness to precocious arteriosclerosis and aging of the tissues. At present the most popular theory is that the disease is due to an antibody-antigen reaction.[4] Some evidence in favor of this type of reaction is the common presence of a reversed albumin-globulin ratio, the presence of rheumatoid factor, a positive lupus erythematosus phenomenon and the histologic similarity of some of the lesions of systemic sclerosis to those of disseminated lupus. Indeed this disease is a collagen disease more than others, since one of its chief manifestations is the proliferation of collagenous tissue. While this seems to be the most promising theory, it certainly cannot be considered proved.

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MALIGNANT SOLITARY PULMONARY NODULE FOLLOW-UP STUDY

O'Connor, Thomas M., Lepley, Derward, Jr., Weisel, Wilson, and Watson, Raymond R., The Department of Thoracic Surgery, Marquette University School of Medicine, Milwaukee, Wis., and Veterans Administration Hospital, Wood, Wis., *Archives of Surgery* 86: 127–128 (June) 1963.

Reports accumulating in the literature indicate that with the early detection and removal of localized stages of bronchogenic carcinoma the survival rate can be markedly improved over that usually quoted for this disease. The solitary pulmonary nodule in a high percentage of cases represents this localized form of carcinoma, and it is often entirely asymptomatic. These facts make the value of roentgen surveys in the early detection of lung cancer readily apparent.

The concept of a significant morphologic factor in the prognosis of bronchogenic carcinoma is further strengthened when these additional statistics are considered.

During the period of this study, 453 patients were admitted to the Wood Veterans Administration Hospital with the diagnosis of primary bronchogenic carcinoma. Resection of the tumor was possible in 100 of these patients, a resectability rate of 23%. All of the patients with malignant solitary pulmonary nodules had resectable lesions, a resectability rate of 100%. Thirty-six of the 453 patients survived five years or more after resection, a survival rate of 7%. The five-year survival obtained in the group of 46 patients whose bronchogenic carcinoma was manifest as a solitary pulmonary nodule was 93%.

Solitary pulmonary nodules, as shown by Steele[27] and others and emphasized again in this group of patients, often represent primary bronchogenic carcinomas. Malignant solitary pulmonary nodules are often asymptomatic and unassociated with positive bronchoscopic or cytologic studies. Therefore early detection depends on roentgen surveys and definitive diagnosis on thoractomy.

The solitary malignant pulmonary nodule is often a localized form of bronchogenic carcinoma and as such has a far better prognosis than bronchogenic carcinoma in general. There is, therefore, no longer any justification for considering the malignant solitary nodule in the same category as other manifestations of this disease.

It is possible to achieve highly satisfactory results with limited resections when treating bronchogenic carcinoma presenting in the morphologic variant of the malignant solitary pulmonary nodule.

DIABETES FILM

The Ames Company, Inc., Elkhart, Ind., announces a new motion picture, "Diabetes—What You Don't Know *Can* Hurt You," produced with the cooperation of the Joslin Clinic in Boston, Mass.

The film discusses in nontechnical language the body processes involved in diabetes, and means of diagnosis and control. It covers all areas of diabetic management, such as insulin; oral therapy; diet; care of equipment; urine testing and complications of diabetes.

"Diabetes—What You Don't Know *Can* Hurt You," a 16 mm., color, sound, motion picture with a running time of 27 minutes, points out the advantages of early detection and treatment. It is available for showings to the medical and nursing professions, diabetic clinics, diabetic lay society meetings and other groups through Ames' Film Department, Elkhart, Ind.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Dipyridamole in Angina Pectoris

By ALBERT C. YARD, Ph. D., M. D.
Milwaukee, Wisconsin

■ UNDERSTANDING DRUG action is a continuous challenge to physician and investigator alike. Unsuspected actions of drugs may be discovered years after their initial testing and even after their broad usage in therapeutics. The discovery of such new effects sometimes means that existing ideas of the mechanism of drug action need to be discarded and replaced by new theories. In many instances the precise mechanism of action of a drug is not fully understood at the time of introduction into general usage, in spite of the fact that in a very general way, the mode of action may be known. This situation applies to dipyridamole (Persantin), a compound intended for use in the management of angina pectoris.

This drug is claimed capable of producing two highly desired effects in cardiac patients: the ability to increase oxygen delivery to the heart by altering the caliber of coronary vessels and the ability to cause more efficient utilization of the oxygen delivered. A drug with credentials as attractive as these must certainly merit comparison with other drugs used in angina pectoris. A review of the factors which control coronary blood flow, and of some new concepts regarding the origin of angina pectoris and its treatment has appeared recently in this column.[1]

The synthesis and initial laboratory study of dipyridamole were carried out in the early 1950's and the compound was marketed in 1959. Chemically, it is unlike the well known nitrites and organic nitrates, but consists of a nucleus of two condensed pyrimidine rings with other substituents on this structure. It was established in the early investigations that in the anesthetized dog, the drug increased coronary blood flow when measured by any of several techniques. Less direct evidence of an increase in coronary flow was also found, such as an increase in small vessel opacification on coronary arteriography and an increase in the oxygen content of coronary sinus blood. The mechanism by which dipyridamole produces these changes is not clear although they do not appear to be caused by an increase in cardiac work. No significant alteration in cardiac work or force of myocardial contraction was found in response to this drug when administered to dogs. An increase in myocardial tissue oxygenation cannot always be presumed when an increase in total coronary flow or an increase in oxygenation of coronary sinus blood is found, as pointed out by James and Nadeau.[2] Measurements of alterations in cardiac tissue oxygen tension would be required to provide this information.

The assertion that dipyridamole increases the efficiency of oxygen utilization by cardiac muscle is based partly on the observation that the drug is capable of increasing the content of the high energy phosphate bearing compound, adenosine triphosphate (ATP) in several in vitro preparations. For example, addition of dipyridamole to beef heart mitochondria which had been injured in order to impair their ability to perform oxidative synthesis of ATP, was found to be associated with accumulation of higher, more nearly normal levels of ATP per unit of oxygen utilized. The atria of guinea pigs pretreated with dipyridamole did not have reduced levels of ATP as did atria isolated from control animals when they were made hypoxic by placing in a nitrogen atmosphere. Since the largest fraction of ATP in cardiac muscle is derived from the process of oxidative metabolism, a drug-induced increase in

ATP levels per unit of oxygen utilized could represent an increased efficiency of the oxidative process. Reduction in rate of ATP breakdown or increased ATP formation by nonoxidative processes could also account for some of these findings. Whether damaged mitochondria or hypoxic cardiac tissue can serve as a useful representation of the human myocardium supplied by atheromatous coronaries is the critical issue to which there is no clear cut answer at present.

Studies of the action of dipyridamole in man serve to emphasize some points basic to the clinical evaluation of any drug. Assessing the value of the drug on the basis of initial reports which suggested an ability to relieve or reduce the frequency of attacks of angina pectoris was difficult because of lack of adequate controls. In some studies, the intravenous route of administration was selected for use in the trials although the oral route is suggested for broad general usage. This presents the hazard that if the compound was poorly absorbed from the gastrointestinal tract, therapeutic results in practice could differ greatly from those in the pilot study. A final point is that a drug proposed for treatment of angina pectoris ultimately must be evaluated in patients meeting rigorous tests for the presence of angina pectoris. Thus, although the actions of the drug in the subject free of cardiovascular disease are important, knowledge of these cannot substitute for adequate double blind studies in patients with coronary artery disease. There are numerous illustrations of the fact that a response to a drug may differ depending on the presence or absence of a pathologic change in the responding organ. One example of this is the finding by Gorlin *et al.*[3] that glyceryl trinitrate caused dilatation of the normal, but not diseased coronary vessels. In some double blind studies of small groups of patients with a history of angina pectoris, dipyridamole was not superior to the placebo. Patients in these studies took the drug for one to three months. The claim has been advanced that maximal benefit occurs only after many weeks of treatment; the question of how this delayed improvement could occur has not been answered. Also unanswered is the basis for lack of benefit in the studies mentioned in spite of the known coronary dilating effect of this drug. There is an obvious need for further study of dipyridamole, both in the laboratory and by controlled clinical trial.

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Clinical and Necropsy Findings in the Rupture of the Myocardium. A Review of Forty-Three Cases

Ross, R. M. and Young, J. A. *University Department of Pathology, Western Infirmary, Glasgow, Scotland Scottish Medical Journal,* 8: 222 (June) 1963.

The authors assessed the role of anticoagulant therapy compared with other factors in the etiology of myocardial rupture. Necropsy records of 8,193 patients were reviewed during the period from 1940 to 1960. There were 606 myocardial infarction deaths, with a rupture rate of 7 per cent or 43 patients.

The age range of patients having a myocardial rupture was from 39 to 81 years (3 patients were below 50 years). There were 27 ruptures in 411 male patients with fatal myocardial infarctions (6.5 per cent), as compared to 16 ruptures in 195 females (8.2 per cent).

All the ruptures occurred in the vicinity of infarction. Only one occurred in the right ventricle; the rest were in the anterior or posterior wall of the left ventricle. In 12 patients, there were extensions to the interventricular septum.

Clinical records of the 43 rupture cases and 83 nonrupture cases (selected at random from the remaining 487 cases) were studied. No patient had received an overdosage of anticoagulant since it was initiated in 1949. Rupture rate in the preanticoagulant period was 10.4 per cent (8 of 77 cases), and 6.6 per cent (35 of 529) in the anticoagulant period. Analysis indicates that anticoagulant therapy does not have any significant effect on the rupture rate.

Twenty-four of the 43 patients with ruptures were found to be hypertensive and 17 (70 per cent) remained so after infarction, indicating that a persistent hypertension is highly significant in producing rupture.

There also was no increased incidence of fibrosis in those patients who avoided rupture. Seventeen of 43 patients who had ruptures (31 per cent) and 29 of 86 controls (33 per cent) showed clear evidence of fibrosis.

The association of increased polymorphonuclear infiltration (grade 2 to 3) was much more common in the patients with rupture than in the control pation. Only 2 of 35 controls had a grade 2 infiltration whereas 9 of 15 with ruptures had such infiltration.—Reprinted from *International Medical Digest,* October 1963.

THE PRESIDENT'S PAGE . . .

W. P. CURRAN, M.D.
Antigo, Wisconsin

Kerr-Mills

■ ONE OF THE MANY important matters that came before the recent meeting of the Society's House of Delegates was the extraordinary session on the Kerr–Mills Law. The meeting was well attended by delegates and alternates as well as by many other physicians. More than two hundred persons representing the interested professions and organizations were guests of the Society at this extraordinary session.

Speakers included Mr. Wilbur J. Schmidt, director of the Wisconsin State Department of Public Welfare, and Mr. Elmer Rasmussen, vice-president, and Mr. Frank Zepeda, representatives of the Continental Insurance Company, who were the successful bidders from the insurance field to administer the program, better known as "The Health Assistance Payments Act."

Federal legislation of the Kerr–Mills bill was enacted in 1960 with the support of the Eisenhower Administration and the American Medical Association. Since that date, numerous state legislatures have enacted legislation for the implementation of health care aid to people who have attained the age of 65 years and who need medical assistance and are not receiving aid from any other type of program. Wisconsin is one of the many states fortunate enough to have such a program. Our plan is the most liberal enacted by any state. It went into effect on July 1, 1964.

That there is much interest in the successful implementation of Kerr–Mills in Wisconsin was evidenced by the many well thought out questions directed to the speakers during the question and answer portion of the program.

There are many aspects of the law which, no doubt, will need the patient cooperation of the vendors, the administrating agency, the Welfare Department and the people who will be the beneficiaries, if our Kerr–Mills law is to be as effective as those who drafted it and as our State Legislature intended.

The major responsibility will fall on the shoulders of Wisconsin physicians since they will be administering or directing others in administering the health care benefits provided for in the law. Many eyes will be watching for the success or failure of this liberal Kerr–Mills law in Wisconsin.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JULY 1964

Vol. 63 No. 7

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Seizing Headlines

■ THE FOOD AND DRUG Administration has earned plaudits in these columns for the responsible job it has done with an undermanned staff. As a federal watchdog agency, it has worked hard to curb quacks, protect the purity of our food and police the marketing of pharmaceuticals. The fact that we can buy food and drugs with a high degree of confidence is a tribute to the effective service of this agency. The FDA figured dramatically in the Thalidomide *affaire*, and in the Kefauver investigation of the drug industry it stood sharply focussed in national attention for its activity on behalf of the entire country.

Has all this notoriety, coming after years of half obscurity, gone to the head of the personnel of the FDA? That this might be true is suggested by a recent incident that merited headlines in the press of the nation.

Along with several other manufacturers, the Helene Curtis company has marketed a cosmetic preparation advertised as capable of removing wrinkles from the skin for a limited period of time. The company had distributed its product widely and apparently invested a sizable amount in promoting it. Suddenly the Food and Drug Administration seized a few cartons of the preparation, charging that it was a drug, not a cosmetic, and that it was therefore subject to the testing procedures required to establish its safety. The action gained the attention of the newspapers, but it is significant to note that the cosmetic drug was not removed from the market, nor was the basically similar product distributed by Helene Curtis' competitors seized.

It should also be noted that to provide further justification for the seizure of the few cartons of the lotion, the FDA alleged that its advertising was misleading.

The Food and Drug Administration is, of course, empowered to seize dangerous drugs in order to stop their distribution. In this instance, however, the FDA didn't stop the distribution of the product; merely confiscated a few cartons. It made no effort to stop the sale of the undoubtedly vast quantity of the product already in the channels of distribution, nor did it try to stop similar preparations under other brand names from being sold. If the wrinkle remover is really a dangerous drug—or at least a drug, the safety of which has not been established—the FDA was

remiss in its duty when it failed to remove it from the market altogether. If it is not a drug, but a cosmetic advertised with extravagant or misleading claims, the situation warranted action by the Federal Trade Commission to force the manufacturer to modify his advertising. Seizure by the FDA is not indicated by misleading advertising.

And, finally, if the FDA believed that Helene Curtis' product was a dangerous drug, why didn't the FDA request that Helene Curtis, who is not a fly-by-night quack, remove the preparation voluntarily before seizure?

These considerations of the Helene Curtis case raise serious doubts as to the intention of the FDA. If its purpose was to obtain additional headlines, it was eminently successful. And its success causes one to wonder if the present administration's avowed espousal of the consumer's welfare hasn't compromised the integrity of the FDA we thought we knew and respected.—D.N.G.

True Friends

When the tide of events runs contrary, it is encouraging to have the help and support of those closest to us. That's why the backing of the Wisconsin State Medical Assistants Society is so welcome as a gesture of moral support. On April 5, 1964, the girls adopted the following resolution aligning themselves with the State Medical Society of Wisconsin in its legislative program:

Whereas, The Wisconsin State Medical Assistants Society is dedicated to the Medical Profession; and

Whereas, Its principal objectives are to render educational services for the self-improvement and education of its members so that they may better serve their doctor-employers and the public; and

Whereas, The Wisconsin State Medical Assistants Society appreciates the support and encouragement of the State Medical Society of Wisconsin; and

Whereas, The issue of federal intervention and government control in the field of medical care is foremost in the thoughts of the members; therefore, be it

Resolved, That the Wisconsin State Medical Assistants Society will continually strive to keep informed on current legislative trends and alert all with whom they come in contact; and be it further

Resolved, That the Wisconsin State Medical Assistants Society would like to go on record as opposing Medicare and pledges its support to the State Medical Society of Wisconsin on all basic legislative issues.

This resolution is clearly more than an empty expression of sympathy with the aims of the medical profession. It speaks of the growing professionalism of a group of women who have long been an important ancillary service to medicine. That they understand our social program and the importance of preserving the machinery that provides a high standard of medical care for the community attests to the seriousness with which they take themselves and their organization.

As they frequently interpose between the doctors who employ them and the public they serve in the course of their duties, it is to be hoped that they will also carry to the community the message of our ideals and what we believe necessary to implement them.

We are grateful to the Medical Assistants Society for their understanding and support and welcome them to the ranks of those who strive for continued high quality of medical care. —D.N.G.

UNAUTHORIZED SIGNATURES ON OFFICIAL OPIUM ORDER FORMS
(Form No. 2513)

Many triplicate copies of official opium order forms are being signed by unauthorized persons. Section 151.165 (a) and (b) of Narcotic Regulations No. 5 states, in part, that the official narcotic order forms shall be signed by the purchasing registrant in the same form as on the application for registration (Form No. 678) or may be signed by another person authorized by power of attorney (Form 1315) previously filed with and approved by the District Director of Internal Revenue. Under no circumstances should other persons sign these forms.

Minutes of Annual Council Meeting

Madison, March 14–15, 1964

1. Call to Order and Roll Call

The Council was called to order at 2:15 p.m. on Saturday, March 14, by Chairman Fox.

All voting members were present except Doctors Frank and Callan, and Doctors Bell and Stoops were absent Saturday evening, Doctor Chojnacki absent Sunday.

Officers and others present were President-elect Curran; Vice-speaker Carey; AMA Delegate Quisling; A. A. Lorenz, M.D., present Saturday for a special order; Doctor Stovall present Sunday morning. Messrs. Crownhart, Ragatz, Toser, Murphy, Tiffany, White, Reynolds, Blaine, Mrs. Anderson and Miss Pyre present for all sessions; Messrs. Hansen and Maroney on Saturday; Messrs. Salt, Johnson, and Mrs. May on Sunday.

2. Approval of Minutes

On motion of Doctors Blanchard-Chojnacki, carried, minutes of the October 1963 meeting were approved.

3. Election of Officers

Doctors Willson-Chojnacki moved that the present officers hold office until the Council meeting following the Annual Meeting of the House of Delegates and that elections be held at that meeting.

Doctor Kief raised a point of order and the Secretary reviewed appropriate provisions of the Constitution and Bylaws and Rules of Order of the Council, the latter providing that the annual meeting of the Council be held the last weekend in February. This was postponed two weeks in 1964 to meet the requirement by the House of Delegates in October 1963 that the Council meet six weeks before the Annual Meeting of the Society.

Doctor Van Hecke suggested that the motion be put to a vote under suspension of rules and that unanimous consent of the Council be called for.

Doctor Mason asked whether in the future the meeting after the Annual Meeting of the Society would be considered the annual meeting of the Council. Doctor Willson said there was nothing in the motion to indicate a change in the annual meeting, but simply to defer elections for two months.

The chair ruled the motion carried on a voice vote.

4. Councilor District Reports

Each councilor present reported generally on activities and conditions in his district. Doctor Schulz commented on the matter specifically referred to him by the Council, that of a doctor's dissatisfaction with local administration of special service claims. He felt that the situation had corrected itself in the time elapsed.

5. Conflict of Interest

The Secretary reported that all officers had signed the certificate pursuant to the statement of policy adopted in 1962, and there were no reports of any conflict of interest with affairs of the State Medical Society.

6. Wisconsin Work Week of Health

On motion of Doctors Ekblad-Chojnacki, carried, the statement by Doctor Egan was incorporated in the minutes that the entire staff of the Society, from Secretary Crownhart across the board, be complimented for their perfect service, attention, and manners; and the Woman's Auxiliary was also thanked for its assistance.

There was general agreement with the recommendation of the Executive Committee that planning begin for a 1965 Health Week.

Mr. Crownhart proposed that as a result of the Work Week of Health, both from those who attended and the sizable group to whom the program was distributed, the Planning Committee undertake a study of arranging some individual and regional conferences on such matters as physician placement problems, school health examinations, and hospital licensing. He also felt that there should be better planning of orientation programs for medical students from both Wisconsin schools, and that the Council or its Executive Committee might well have a convocation of all chairmen of Society committees.

On the matter of medical student programs, Doctor Kief thought that they should be reached as freshmen before certain ideas become fixed, and brought back as juniors or seniors.

On motion of Doctors Kief-Van Hecke, carried, the proposal of inviting medical students to the State Medical Society for educational purposes was referred to the Planning Committee to develop a program and carry it out sometime in 1964.

7. Reports of Committees to House of Delegates

House action of October 1963 requires that committee reports be available to the Council at least six weeks before the meeting of the House to which submitted.

The Council received and reviewed in detail the following reports:

(a) Commission on State Departments and Divisions on Aging, Handicapped Children, Maternal and Child Welfare, Nervous and Mental Diseases, Rehabilitation, School Health, and Visual and Hearing Defects
(b) Commission on Medical Care Plans
(c) Committee on Health Economics of American Life
(d) Committee on Grievances
(e) Commission on Public Relations and Communications
(f) Commission on Hospital Relations and Medical Education
(g) Committee on Cancer
(h) Menominee County Study Committee

On separate motion duly made, seconded and carried, the reports were accepted for transmittal to the House of Delegates, with some minor editorial revisions and deletion of portions of the report of the Division on Nervous and Mental Diseases (see next item in minutes).

8. Mental Health Laws and Facilities —Special Order

The Executive Committee had invited Doctor Lorenz to report on this general subject. He submitted a report on activities of the Comprehensive Mental Health Planning Committee of which he is a member representing the State Medical Society.

Doctor Lorenz was also present during presentation and discussion of the report of the Division on Nervous and Mental Diseases of the Commission on State Departments.

Both reports contained recommendations concerning postgraduate education in psychiatry for the general physician, and for this purpose that government grants be investigated, particularly from the National Institute of Mental Health.

The principle of utilizing government funds in this manner was discussed at considerable length, and action was taken following dinner recess.

Doctors Nordby-Kief moved acceptance of the Division report with deletion of sections 2 (b), (c), and (d), and section 10, with authorization of a circuit teaching program through the CES Foundation as a one-year trial to meet the needs of the teaching of psychiatry to local practitioners. (Section 10 related to the Mental Health Compact Bill which was indefinitely postponed by the Legislature, and the Council felt Society action should therefore be deferred.) The motion carried by a vote of 9–7, and Doctor Nadeau asked that his negative vote be recorded.

The Council asked that the Division give further study to the matter of using federal funds during the trial period of postgraduate education through the Foundation.

9. Report of Committee on Scientific Medicine

Doctor Van Hecke reported as follows for this committee of the Council which met Saturday morning:

a. Commission on Scientific Medicine

"The suggestion of amending the bylaws to provide additional members on this standing committee was referred to the Council's Committee on Scientific Medicine by the Executive Committee. Inasmuch as the bylaw specifies that each member serve for a period of five years (and not be eligible for reappointment), it would appear most logical to increase the size of the Commission from the present five members to ten. Therefore, it is recommended that section 2 of Chapter VII be changed to read, in the second line, '10' instead of '5.'

"The bylaw provides that members of the Commission be appointed, and it has been customary to have the Commission on Scientific Medicine make recommendations to the President-elect for such an appointment by way of submitting a slate of three nominees. While the President-elect is not duty bound to accept these recommendations, it has been rare that the recommendations of the Commission have not been followed.

"It should be pointed out that while the bylaw does not specify the character of the membership of the Commission, it has attempted to have representation from the two medical schools, in addition to the two deans serving in an ex officio manner.

"If the Council accepts this recommendation to favor the introduction of a resolution increasing the size of the Commission from 5 to 10 appointed members (which would mean two appointees each year), it might be well at the same time to introduce a second revision of section 2, Chapter VII, by adding one word to the sentence which now reads: 'It shall also be in charge of the affairs of the *Journal*.' Inasmuch as the Commission on Scientific Medicine is in no way responsible for editorial policy, the business affairs of the *Journal*, etc., it might pinpoint the responsibilities of the Commission better to insert the word 'scientific' before the word 'affairs' in the sentence quoted."

On motion of Doctors Kief-James, carried, this portion of the report and recommendations were accepted.

b. Osteopathic Conference on Maternal Mortality

The Scientific Committee's recommendations had been forwarded to the Council by the Executive Committee, as follows:

(1) That the State Medical Society as such does not directly sponsor such a teaching program for osteopaths.
(2) That the Bureau of Maternal and Child Health of the Wisconsin State Board of Health conducts such a conference, and invites the Maternal Mortality Study Committee to provide the instructional program.
(3) That all announcements and the program of such a conference restrict sponsorship to the State Board of Health, and do not identify the State Medical Society of Wisconsin with the program in any manner.
(4) That such a conference be held in Milwaukee on a date agreeable to the Bureau of Maternal and Child Health and the Wisconsin Osteopathic Society; that it be held in a location which will not have any medical connotation, and that no funds of the State Medical Society be used to finance the program in whole or in part.

On motion of Doctors Kief-Houghton, carried, this portion of the report was accepted.

c. Participation of Nonmembers in the Annual Meeting and Other Society Teaching Programs

"Some question has been raised as to the current regulation of restricting attendance and participation in the Annual Meeting and other Society teaching programs to dues-paying members. The Scientific Committee feels that the current regulations are reasonable and should be continued, but at the same time it is urged that the Council initiate a broad study of membership classifications, dues for various types of physicians (as well as others who do not possess the degree of doctor of medicine but are closely associated with medical practice, in our medical schools), and other matters which will include the relationship of nonmembers to Society affairs. The Scientific Committee urges that efforts be made to acquaint nonmembers with the broad benefits of Society programs which are supported by dues, in an effort to secure more active participation by physicians who at the present do not elect to carry membership in the State Society."

On motion of Doctors Nordby-Wright, carried, the recommended study was approved.

d. La Crosse as Annual Meeting Site in 1965

"The Scientific Committee suggests that the Assistant Secretary meet with physicians in La Crosse who have suggested holding the Annual Meeting in that city, to fully acquaint them with the facilities needed within a single building to make the meeting successful. If after such a meeting there is an indication that action of the House in May 1963, declining the invitation of La Crosse to conduct the Annual Meeting there, should be reconsidered, such action can be taken by appropriate resolution introduced at the meetings of the House in May."

This portion was accepted without formal action.

e. Promotional Assistance for Attendance at the Annual Meeting

"With changed regulations for educational credits within the structure of the American Academy of General Practice, there has been

some concern expressed as to the attendance of Wisconsin Academy of General Practice members at subsequent Annual Meetings of the State Society. The Scientific Committee suggests that an analysis of attendance next May be made to see if there has been a significant decrease in the attendance of members engaged in general practice, and if so, that the subject be further discussed with officers of the Wisconsin Academy of General Practice."

This was reported to the Council for information.

The Council recessed at 9:50 p.m. until 9:35 a.m. on Sunday, March 15, when it convened as members of the SMS Realty Corporation, then resumed the Council agenda at 10:30.

10. Report of Finance Committee

Doctor Dessloch, chairman, reported that the Committee had met first in February when, as trustees of the Pension Plan, it received a certification of employees eligible in 1964, and also received the Pension Plan audit by Donald E. Gill & Co. It approved the SMS Realty Corporation budget at that meeting, and gave initial consideration to the SMS budget, which was reviewed again on March 14.

He presented the 1964 budget as recommended by the Finance Committee, summarized as follows by account totals:

Dues—Membership and Supporting	$ 1,460
Conference Expense	23,150
Promotion	6,100
Depreciation	3,000
Grants and Appropriations	3,700
Insurance—General	2,500
Miscellaneous Expense	3,000
Office Supplies and Expense	3,200
Outside Services	7,550
Postage	11,700
Printing and Forms	52,450
Rent—Office	37,500
Rent—Other	6,500
Rental—Other Equipment	1,500
Repairs and Maintenance of Equipment	1,000
Resource Material	975
Speakers' Expense	5,500
Property Tax—Personal Property	350
Telephone	3,400
Accounting Services	6,000
Legal Services—Normal and Special	7,200
Legislative Retainer	8,900
Special Budgetary Provisions	21,350
Staff Travel Expense	5,450
Payroll	120,952
Related Payroll Expenses	12,600
Field Service	40,200
	$397,187

Special Budgetary Provisions included the special mailing list for TODAY'S HEALTH and AMA NEWS, the Work Week of Health, and the Conference on Health Fads and Fallacies.

Anticipated income was conservatively estimated as follows:

Dues, all membership classifications	$305,000
Wisconsin Medical Journal advertising	45,500
Annual Meeting	29,500
Dues, Section on Medical History	600
Reimbursement from Dane County Medical Society	1,800
Reimbursement for work performed, and supplies used, other divisions including Field Service	14,000
Miscellaneous (reprints, bound copies of Open Panel, etc.)	1,500
	$397,900

In commenting on the budget, Mr. Crownhart stated that:

First, it is accepted that WPS and other operations in no manner reflect to the financial advantage of the dues structure. This brought into administrative concept the prorating of certain salaries and related costs. However, this in turn has caused a problem in that, as one example, where there was a prorating of a group providing some special service (such as multilith and other machine services) and that group of employees was increased in size, the cost to the dues structure was not adjusted rapidly enough to provide the stability inherent to successful budgetary management.

Also, as the organization has grown in number of employees, there is a natural tendency for more to share in assignments to a point that measurement of time becomes ineffective.

Therefore, the 1964 Budget insofar as salaries are concerned is returning so nearly as can be achieved this year to the inclusion of specific positions serving Society needs on a full-time basis.

There are 17 full-time employees paid out of the dues structure. There are two full-time employees paid out of the *Wisconsin Medical Journal* income. In addition, the salaries of Miss Pyre, Executive Assistant, and Mrs. Anderson, Personnel Director, are allocated as follows:

Miss Pyre	SMS 50% WPS 50%
Mrs. Anderson	SMS 25% SMS Realty 25% WPS 50%

The salary of a stockroom clerk is also carried on an allocated basis of SMS 20% and WPS 80%.

The SMS staff will take over its own purchasing by utilizing the same system, so that accounting will not be confused. (It actually handles the great bulk of its own purchasing now through *Wisconsin Medical Journal* personnel, Mr. Ragatz and others.)

The entire field service will be placed on SMS payroll in total amount, without subsidy; where field service actually performs a function for WPS, it will bill for it at an hourly rate, plus the 55% overhead.

Second, the budget has not previously contained a contingency fund to carry any expenses authorized after the budget is approved. Example: the determination that the lawsuit involving the argument that chiropodists are in fact physicians was more properly a charge of the Society than of its insurance operation. While but a modest amount can be budgeted for 1964, at least a beginning is made.

Third, for various reasons not detailed here, the number of meetings has been increased. Administratively, and particularly as to committees composed of councilors and officers, these will be held as much as possible preceding and following meetings of the Council. This should reduce the number of trips involving councilors and officers and make their assignments easier. And there should be some measurable effect on costs of operation.

On motion of Doctors Dessloch-Ekblad, carried, the budget was approved except that AMA delegates and alternates will receive an allowance of $500 for each meeting attended, in view of past inconsistencies in individual billing of associated expenses.

John White, C.P.A., distributed certified balance sheets and statements of income and expense for the Society, its divisions, and related organizations as of December 31, 1963. He reminded the Council that the House of Delegates had received complete audit reports at the October 1963 interim session,

and at that time asked for briefer reports in the future.

The Council accepted the recommendation of the Finance Committee that these certified statements be submitted to the House in May.

11. Report of Executive Committee

The following matters from intervening meetings of the Executive Committee were reported for action or information:

a. Associate Society Counsel

On motion of Doctors Van Hecke-Dessloch, carried, the Council confirmed the appointment of Mr. John Kluwin of the firm of Kluwin, Dunphy, Hankin and Hayes, as associate general and legislative counsel.

b. Schedule of Council Meetings

In light of the requirements by action of the House that the Council meet six weeks before meetings of the House to receive reports of committees, and that it meet immediately following the Annual Meeting, the Executive Committee reported its belief that a brief meeting Sunday afternoon will comply with the present bylaw.

It recommended that a bylaw amendment be introduced in May to eliminate the requirement now specified that the Council meet the day immediately preceding the Annual Meeting. The Council accepted this recommendation.

The Committee reported further that a change in its schedule of regular meetings is indicated and suggested, in addition to meetings associated with the annual and interim meetings of the House, meetings in March and September to meet the six-weeks requirement, and the summer meeting in July. No formal action was taken.

c. Reimbursement Procedures

A House resolution calls for a report by the Council in May of a policy on reimbursement of members for expenses incurred in attending meetings of (or in behalf of) the Society.

The following outline of existing policy, amended per action regarding AMA delegates, was approved by the Council for report to the House of Delegates. In each instance it is applicable when attendance at meetings is authorized.

(1) Council: pay whatever expenses are billed for in-state or out-of-state meetings
(2) AMA delegates and alternates: an allowance is established in the annual budget for each meeting attended
(3) President: an allowance for in-state and out-of-state travel is established in the annual budget and reimbursement is made as billed
(4) SMS committee members: pay whatever expenses are billed for in-state and out-of-state meetings
(5) Commission on Medical Care Plans: WPS pays expenses billed for both in-state and out-of-state meetings

d. Vice-chairmanship of Divisions of Commission on State Departments

The Executive Committee recommended, and the Council approved, that if a Division considers a vice-chairman essential, it should submit a slate of nominees to the Council for election.

The Division on Nervous and Mental Diseases wished to create a vice-chairmanship, and had submitted nominees.

On motion of Doctors Bell-Nordby, carried, Doctor Lorenz was elected vice-chairman.

e. Closed Chest Cardiac Resuscitation

The Committee on Clinical Medicine had met with representatives of the Wisconsin Nurses Association and prepared a joint policy statement intended as a guide to nurses presented with a cardiac arrest. The Executive Committee had reviewed it and recommended Council approval.

Subsequently, however, the Wisconsin Nurses Association advised that it was not being recommended to the Board of Directors without some minor changes first being made.

On motion of Doctors Nordby-Mason, carried, the subject was tabled.

f. Check Signing Authority

With the departure of Assistant Secretary Thayer, only the Secretary and Assistant Secretary Ragatz are authorized among the staff to countersign checks, enter safety deposit boxes, etc. There are occasions when both are unavailable.

On motion of Doctor Dessloch, seconded and carried, the Secretary was authorized to designate any person who occupies the classification of executive assistant for this purpose.

g. Section on General Practice Resolution of May 1962

The Committee reported for information that it met with representatives of the Section on General Practice, having met previously with the Section on Surgery concerning its response to the resolution which relates to surgical assistants.

It was concluded that legal counsel for the Society and the AMA be requested to prepare a statement relating the Wisconsin statute to pronouncements of the Judicial Council.

h. Relationships with Osteopaths

Counsel for the Wisconsin Osteopathic Association met recently with Society counsel to request further meetings between the two organizations. This was referred by the Executive Committee to the chairman of the Planning Committee.

i. Costs of IRS Examination of Society and Divisions

The Executive Committee directed that initial costs during 1963 of time provided by auditors in gathering information and consultation regarding the various activities be allocated on a cost basis between SMS and WPS, but that costs involved from the point of controversy in determining the status of WPS as an activity within the purposes of the Society be charged to that activity.

j. Past President's Lapel Pin

The Council was shown the design of a lapel pin to be provided living past presidents and widows of those deceased.

12. Certification of Psychologists

The Secretary reported that this subject has been before the Commission on Public Policy and is also under study by the Division on Nervous and Mental Diseases and others.

The Commission has recommended that the Council assume jurisdiction of the subject and assign it to an appropriate committee.

On motion of Doctors Nordby-Dessloch, carried, it was assigned to the Planning Committee for report back to the Council.

13. Report of Secretary

Mr. Crownhart commented on attendance at the conference for county society officers concluding the Work Week of Health, at which but one-half of the county societies were represented.

He read resolutions just received from Manitowoc and Waupaca county societies, which will be distributed with committee reports.

125th Anniversary in 1966: Mr. Crownhart proposed that under the chairmanship of Doctor Curran and the joint chairmanship of the physician elected president-elect in May, with all past presidents serving as committee members, planning be started at this time for a series of events to celebrate the anniversary in 1966.

Doctors Nordby-Van Hecke moved to approve this proposal, incorporating the suggestion of Doctor Dessloch that the past presidents be organized on a permanent basis. Motion carried.

14. Report of Committee on Cancer

Several items in the Committee's report to the House were also referred specifically to the Council, which felt that its acceptance of the report and forwarding to the House was the only action necessary. It did feel that the reference committee should be provided with additional information regarding United Health Foundations, Inc., preferably by Doctor Frank.

15. Polk County Medical Society Charter

On motion of Doctors Van Hecke-James, carried, the Council approved reissuance of the lost charter of the Polk County Medical Society as of the date of original issue, September 9, 1930.

16. Miscellaneous

a. Doctor Mason reminded the Council of the Conference on Health Fads and Fallacies to be Held in Port Edwards, April 17–18, and urged the members to stimulate attendance from their respective areas.

b. On motion of Doctors Nordby—Ekblad, carried, the Council commended Doctor Dessloch for his long years of service and his fine performance in the office of president of the SMS Realty Corporation.

c. Appointment of Consultants

Doctor Nordby said he understood that the consultants had been appointed some years ago on the basis that they were continued until replaced, but in view of various inquiries he suggested that the Council take positive action.

On motion of Doctors Nordby-Ekblad, carried, the following were appointed as consultants to the Society and Council:

Mr. Donald E. Gill, certified public accountant
Mr. Robert B. Murphy, general and legislative counsel
Mr. Carl A. Tiffany, actuary

d. Medicine and Pharmacy

Doctor Davis reported briefly on his attendance at the first Congress on Medicine and Pharmacy held in Chicago just preceding the Council meeting, on authorization by the Executive Committee. He suggested that he report in detail to the Planning Committee, and the subject will come back to the Council through the Executive Committee.

17. Adjournment

The meeting adjourned at 12:40 p.m., Sunday, March 15, 1964.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman

STATEMENT ON MEDICAL USE OF ADDICTIVE DRUGS

As adopted by the Division on Nervous and Mental Diseases on January 19, 1964, and approved by the Commission on State Departments on March 8, 1964

I. DEFINITION OF DRUG ADDICTION.
A state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means.
2. A tendency to increase the dose.
3. A psychic (psychological) and generally a physical dependence on the effects of the drug, with withdrawal symptoms including possibility of convulsions and even death.
4. An effect detrimental to the individual and to society.

II. GENERAL TYPES OF ADDICTING DRUGS.

1. Opiates, e.g., opium, morphine, heroin, and the synthetics.
2. Stimulants under federal regulations (habituating), e.g., cocaine, marijuana, and peyote.
3. Barbiturates and nonbarbiturate sedatives.
4. Certain tranquilizing or psychic-energizing drugs.

III. RECOMMENDATIONS.
Avoid ambulatory withdrawal therapy for narcotic addicts.

1. Use of hospital facilities rather than ambulatory treatment as available under voluntary and compulsory commitment sections of the Wisconsin Statutes at Winnebago and Mendota State Hospitals.
2. For non-narcotic addicts, use of private hospital facilities as optimally withdrawal is best carried out in a closed, specialized narcotic treatment unit since it requires a drug-free environment.
3. That all physicians limit the quantity and refill authorizations for all drugs that have addicting and habituating possibilities.

the wisconsin medical journal

VOLUME 63/NUMBER 8 AUGUST 1964

Management of Massive Upper Gastrointestinal Hemorrhage

By CHARLES MARKS, M. D., M. R. C. P., F. R. C. S., Milwaukee, Wisconsin

■ THERE IS AN undoubted dramatic quality to the clinical presentation of a patient with massive gastrointestinal bleeding. The drama is compounded by the patient's frightening physical and emotional reaction and by the diagnostic and therapeutic problems it poses to the attending physician.

To see a patient presenting with massive hematemesis in shocked, restless state with tachycardia and hypotension associated with oliguria, allied with marked emotional response imposes a burden on the medical attendant. The physician must, on the one hand, apply empiric resuscitative measures with replacement of blood by transfusion, allay shock and distress with appropriate sedation, while at the same time obtain a coherent history and carry out a careful clinical examination that will permit him to make an exact diagnosis of the underlying mechanism and thereby apply the best procedures to stop the bleeding and consider methods to anticipate and prevent recurrence of the bleeding.

Massive Hemorrhage. It is, of course, necessary to establish the criteria of massive hemorrhage and these would be: (1) hemoglobin level, 8 Gm. per 100 ml. or less; (2) hematocrit reading, 25% or less; (3) profound shock; and (4) blood pressure, 40 mm. Hg. below normal.

Strategy of Immediate Management. It is important to appreciate that immediate death from acute intestinal hemorrhage is most unusual. The immediate administration of saline solution, plasma or blood volume expanders is commenced while blood matching procedures are being carried out and a reserve of at least six units of whole blood should be provided.

The prompt and adequate blood replacement should be complemented by immediate bed rest and sedation, while the placement of a nasogastric tube permits the stomach to be emptied and provides evidence of recurrent or continuing bleeding.

A full and thorough clinical evaluation is necessary to exclude the possibility of swallowed blood after an hemoptysis and the presence of pulmonary tuberculosis, bronchiectasis, pulmonary neoplasm, pulmonary infarction, or pulmonary congestion due to mitral valve disease will suggest this mechanism. Equally, a thorough hematologic study will serve to exclude hemorrhage due to thrombocytopenia, bleeding, or clotting disorders.

The dangers of overtransfusion are always present and careful scrutiny of the neck veins and, where indicated, measurement of venous pressure will avoid these dangers.

Presented before the Waukesha County Medical Society, Jan. 8, 1964.

Doctor Marks is Associate Professor of Surgery, Marquette University School of Medicine, and Attending Surgeon, Milwaukee County General Hospital.

Depleted blood volume effects are common in elderly patients, and even after restoration of blood volume these patients may die of a cerebrovascular accident, myocardial infarction, bronchopneumonia, or renal failure. Thus it is important to recognize the elderly patient who continues to bleed, bleeds massively or repeatedly, and who may go into a state of irreversible shock and die of these intercurrent episodes.

Etiology of Gastrointestinal Hemorrhage. *Peptic ulcer:* Seventy per cent of patients have an ulcer of the stomach or duodenum, while occasionally peptic esophagitis due to a sliding hiatus hernia provides a source of hemorrhage. A peptic ulcer of a Meckel's diverticulum may be a source of massive intestinal bleeding, and occasionally hemorrhage may occur in a stomal ulcer after a previous gastric resection or gastroenterostomy.

Esophageal varices: Portal hypertension with bleeding from esophageal varices may be attributable to many factors, although in clinical practice, cirrhosis of the liver is the most important cause and provides 20 per cent of cases of massive gastrointestinal bleeding. It is important to appreciate, however, that in one-third of these cases concomitant peptic ulcers may be the source of hemorrhage, often presenting after portacaval shunting procedures. This is attributable to acid-stimulating factors which bypass the liver and hence avoid degradation via portasystemic collaterals.

Gastric neoplasms: These neoplasms, either benign or malignant may be a source of hemorrhage. Benign tumors include adenoma, polyposis, leiomyoma, and schwannoma, while the presence of the Peutz–Jeghers syndrome will be manifested by cutaneous and mucosal focal areas of pigmentation. Both carcinoma and gastric lymphosarcoma may be a source of hemorrhage. Gastric erosions may follow ingestion of salicylates or ingestion of corrosive poisons and may be a source of massive hemorrhage.

Diagnosis. A careful clinical history and thorough examination should permit differentiation between a gastroduodenal lesion and esophageal varices.

Patients with variceal hemorrhage may show overt signs of hepatic dysfunction in addition to signs of exsanguination. Suggestive features include: hepatomegaly, splenomegaly, icterus, ascites, gynecomastia, spider nevi, and the presence of enlarged abdominal veins. Hemochromatosis or bronzed diabetes or the parkinsonism of hepatolenticular degeneration indicates specific forms of hepatic cirrhosis.

Repeated observations of vital signs should be complemented by laboratory studies including hematocrit and hemoglobin estimations as well as a check on clotting and bleeding mechanisms. Hepatic function studies should be instituted, and our preference is for estimation of serum proteins, serum bilirubin, bromsulphalein retention tests in the absence of jaundice and prothrombin times. Also carried out are thymol turbidity and cephalin flocculation, alkaline phosphatase, blood sugar, and blood urea nitrogen estimations.

An intake and output chart provides control of fluid administration as well as a check of urinary output, while any concern about myocardial status leads us to perform electrocardiography.

Visualization of Bleeding Site. Esophagoscopy and gastroscopy permit visualization of varices, esophagitis, and of ulcers in many cases, while an esophagogram and early gastrointestinal series during a period of quiescence often provide positive information.

Our procedure of choice in suspected variceal hemorrhage is percutaneous transplenic portal venography. This is carried out under local infiltration anesthesia, and immediate splenic pulp pressure manometry is carried out. We accept 220 mm. of saline solution pressure as the uppermost limit of normal. Injection of radiopaque material utilizing 20 to 30 ml. of 50% diatrizoate sodium (Hypaque) provides radiographic visualization of the splenic and portal veins and of collateral channels supplying varices in the esophagus and gastric cardia and fundus. It differentiates the intrahepatic obstruction of cirrhosis from the extrahepatic block due to portal or splenic vein thrombosis, extrinsic portal vein pressure by masses, cysts, aneurysms or pancreatic disease and in young patients demonstrates the congenital atresia or stenosis of the portal vein often with a cavernous malformation in this area.

Management. *Bleeeding peptic ulcer:* Management of a bleeding peptic ulcer has been confused in the past by opposition between

supporters of medical and surgical treatment. Greater understanding of the pathology of ulcer disease and appreciation of the importance of age and the condition of the patient has dissolved those differences and has permitted a better rationalization of the special circumstances which permit either nonoperative or operative management.

Improvements in medical management of patients suffering from peptic ulcer hemorrhage are based on: (1) replacement of blood and fluids avoiding electrolyte depletion; (2) sedation; and (3) neutralization of acid with early feeding, antacid, and anticholinergics which permits medical maintenance so that even late definitive surgery can be carried out with success.

In general, however, if emergency surgery is necessary, then the earlier intervention is carried out the better the prognosis. In the elderly patient, in order to avoid the late sequelae of irreversible hypotension, it is better to treat surgically by the second posthemorrhagic day to prevent the patient from dying on the seventh or eighth day. The younger patient, i.e., under 40 years of age, does not generally run this danger and greater latitude is permissible.

It is my practice to carry out immediate surgery in patients over 40 years of age with gastroduodenal bleeding due to established chronic ulceration with the following features: massive bleeding, continuance of bleeding in spite of treatment, a history of previous bleeding, epigastric pain indicating ulcer activity, and concomitant perforation or obstruction.

Emergency Operative Maneuvers. The primary aim is to stop the bleeding after its localization either by gastrotomy or duodenotomy. This is a lifesaving maneuver and is the aim in the patient with exsanguination and a hemoglobin level less than 8 Gm., or one requiring 3 or more units of blood per 24 hours. Either direct suture with absorbable chromic catgut suture or electrocoagulation of the bleeding spot is always possible. This achieved, the surgeon should pause and consult with the anesthesiologist to consider the important question of whether a more definitive procedure should be done. If the patient does not improve significantly, nothing more should be done; if improvement occurs, a definitive procedure may be carried out.

Definitive Operative Procedure. Although some surgeons would prefer to carry out pyloroplasty and vagotomy, my practice has been to perform a subtotal gastric resection. At this time it is important to look for concomitant ulcers which are present in 5 per cent of these patients by feeling the open duodenal end and by palpation and inspection of the mobilized open end of the stomach.

Restoration of continuity has been by a Billroth I type of gastroduodenostomy in gastric ulcer cases. In bleeding duodenal ulcers, I generally close the duodenal stump and perform a Pólya–Hofmeister gastrojejunostomy utilizing a short antecolic jejunal loop.

Bleeding Esophageal Varices. *Emergency Treatment:* Immediate control of variceal hemorrhage is possible in a high proportion of cases by correct placement of a Sengstaken–Blakemore tube. While the bleeding has been controlled with tube tamponade and blood replacement is in progress, a plan of action can be determined within the ensuing 48 hours. I would not permit tube compression to continue beyond this period since the dangers of mucosal erosion and of aspiration pneumonia are very real. Also during this time the patient should never be left unattended as asphyxial deaths caused by the patient's traction on the tube are not unknown.

During this time, control or prevention of hepatic coma may be necessary. This is done by (1) evacuation of decomposing blood; (2) oral antibiotic therapy; tetracycline or neomycin are the most effective in reducing the intestinal ammonia-producing organisms; and (3) glutamine or L-arginine may be administered in the attempt to stimulate conversion of ammonia to urea.

Operative control of bleeding: Transthoracic esophagotomy and direct variceal suture is a lifesaving measure and should be considered early if tube tamponade is ineffective.

If one is confronted with this problem during an injudiciously performed laparotomy, then the best procedure is a transgastric section after complete mobilization of the stomach and re-anastamosis with a running hemostatic suture. This temporarily disconnects the portal and systemic venous systems.

Splenectomy is indicated only in the rare splenic vein thrombosis, while hepatic artery ligation is not recommended.

Definitive Surgery. If the patient's general condition was good and the physician found he was unable to control the bleeding by any other means, he should certainly consider an early shunting procedure if the hepatic status was acceptable. The indications are: (1) serum albumin over 3 Gm. per 100 ml., (2) serum bilirubin less than 4 mg. per 100 ml., (3) prothrombin time over 60% of normal, (4) blood ammonia less than 100 μg. per 100 ml., and (5) other liver tests not unduly deranged.

Shunt surgery would certainly be contraindicated in the presence of severe jaundice, coma, or known progressive hepatic deterioration.

Type of Shunt. Having decided to perform a shunting procedure, there is little doubt in my mind that a portacaval shunt is the best available procedure; and in the past I always performed an end-to-side anastamosis as the preferred technique, but in the presence of encephalopathy or ascites a side-to-side anastamosis would be preferred.

A lieno-renal shunt would be my procedure of choice if the portal vein was unavailable or hypersplenism was the dominant factor, while an anastamosis between superior mesenteric vein and inferior vena cava would be carried out if the portal vein was unavailable and the spleen had been previously removed.

Summary. It should be emphasized that the challenge is great in handling cases of massive gastrointestinal hemorrhage. The patients are seriously depleted with serious underlying pathology. It is necessary to diagnose with accuracy the nature of the underlying lesion and to assess the patient frequently during his changing status. Then the decision must be made whether to operate, and if so, whether on the stomach or portal system. If operation is on the stomach, one must decide whether to deal with the bleeding point only or to carry out a definitive resection. If on the portal system one must again decide whether to attack directly the bleeding area or to use a definitive decompressive operation.

8700 West Wisconsin Avenue (53226).

FEDERAL FUNDS AVAILABLE FOR COMMUNITY MENTAL HEALTH CENTERS

Regulations under which States may apply for Federal funds to help build community mental health centers have been approved by Secretary of Health, Education, and Welfare Anthony J. Celebrezze.

The "Community Mental Health Centers Act of 1963" authorized $150 million for assistance in constructing such centers during the next three years. The law provides for Federal funds to cover up to two-thirds of the construction cost of each center. The funds will be alloted to States on a per capita income and population basis.

The program will be jointly administered by the National Institute of Mental Health and the Division of Hospital and Medical Facilities, both agencies of the Department's Public Health Service.

According to the regulations, to be eligible for Federal funds a center must be a part of a program providing "at least the essential elements of comprehensive mental health services." These are defined as inpatient and outpatient services, partial hospitalization, and emergency services 24 hours a day in one of these three, together with consultation and education services to community agencies and professional personnel.

Copies of the regulations, as printed in the "Federal Register," are available from the Community Mental Health Facilities Branch, National Institute of Mental Health, Bethesda, Maryland.

Applications for the construction funds can be made by public or other non-profit organizations through the State agency (State Board of Health in Wisconsin) designated by the Governor to administer the program, and must be part of the required State plan for construction of community mental health centers.

All of the services defined by the Regulations as "essential" must be provided either by the facility for which funds are requested, or must be part of a total program involving already established facilities in the community which provide these other services.

For additional information please call Lura Jackson, 49-64795, Publications and Reports Section, National Institute of Mental Health, Bethesda, Maryland 20014. June 1964.

"Missed" Fractures of the Cervical Spine

By ROBERT W. BAILEY, M. D., Ann Arbor, Michigan

■ THE MAJORITY of fractures and dislocations of the cervical spine offer no great problem in recognition. The history and physical findings suggest that such an injury exists, and the roentgenograms serve to establish an accurate diagnosis of the nature of skeletal damage. However, such lesions have been overlooked or "missed," and contrawise normal developmental variations have been misinterpreted as representing fracture or dislocation. Although these occasions are not common, their frequency in a recent study of 335 fractures and dislocations of the cervical spine reported by Stover, Metten, and the author[1] seemed significant and are presented as individual cases to best illustrate the pitfalls leading to the error in diagnosis.

The factors which led to these errors are: (1) inadequate roentgenographic examination in type and quality, (2) improper interpretation of the x-ray films, and (3) failure to consider cervical spine injury in the multi-injured individual.

Roentgenograms are obtained following a careful history and physical examination including a precise neurological evaluation. Proper x-ray evaluation includes an initial scout lateral examination of the cervical spine. After this has been interpreted, anteroposterior, oblique views and open-mouth films of the atlanto-axial joint are obtained. It is essential that these be of good quality and that the cervicodorsal junction be adequately visualized.

Interpretation of Cervical Spine Roentgenograms. Obvious fractures and dislocations offer no great problem in recognition, while others of less severity require close scrutiny of all roentgenograms available (Fig. 1).

On the lateral view, attention is first directed to the general contour of the spine and any alteration in the normal cervical lordotic curve is looked for. In hyperextension injuries, a sharp increase in the normal lordosis may be observed at the area of dislocation. In flexion injuries, the opposite may be true, with a kyphotic area present at the site of injury. Care must be exercised in interpretation of the height of the vertebral bodies. In the older child and adult, the height of the vertebrae anteriorly and posteriorly are the same. A wedge deformity might therefore indicate compression fracture of the vertebral body. In children less than 8 or 9 years of age, the ossification of the anterior-superior portion of the cervical vertebrae, especially the third and fourth, is somewhat

Fig. 1—Severe fracture-dislocation of C5 on C6 with quadriplegia. No problem in recognition.

From the University of Michigan Medical Center.
Presented before the Wisconsin Surgical Society at the 123rd annual meeting of the State Medical Society of Wisconsin, May 9, 1963, Milwaukee.

slower than the posterosuperior portion leading to a somewhat wedge-shaped appearance of the vertebrae which might be, and has been, misinterpreted as a compression fracture (Fig. 2).

The height of the intervertebral disk space at the site of fracture-dislocation often is markedly decreased at the point of injury.

Evaluation of the overall alignment of the vertebrae and proper vertebral relationship can be aided in three ways on the lateral examination. Normally, the posterior aspects of the vertebral bodies follow a continuous line which is smooth and unbroken. A line may be drawn on the roentgenograms, and the existence of a break in this line would arouse strong suspicion of dislocation or fracture. Study of the spinous processes and their relationship is of extreme import. Not commonly emphasized is the relationship that the spinous processes have to one another. Normally, the long axes of the spinous processes are so related that if a line were drawn through their long axes, all lines would tend to converge to a central point posterior to the neck. Lack of such convergence or actual divergence is observed when the interspinous ligaments have been damaged and is commonly seen in the flexion type of fracture-dislocations. Failure of these lines to converge should draw attention to the need for further analysis of the x-ray films for evidence of dislocation. The interarticular facets can be seen on the lateral films, but these relationships cannot be as accurately analyzed as on oblique views. The facets should, however, be carefully inspected since gross dislocations can be identified in the lateral view, and close analysis may reveal the presence of fracture of the facet or pedicle (Fig. 3).

Normally, the posterior surface of the anterior portion of the atlas is in close relationship to the odontoid process. Also, the posterior neural arch of the atlas, although without a spinous process, tends to follow the rule of convergence as seen in the spinous processes of the other cervical vertebrae.

Fig. 2—Lateral in child, age 8 years. Note failure of ossification of the anterasuperiar partian of the third cervical vertebra. This has been erraneously interpreted as a compressian fracture ar a fracture-dislacation of C2 on C3.

Fig. 3—Flexian fracture-dislocatian, C5 an C6. Nate the divergence af spinous processes between C5 and C6; break in narmal smooth line alang pasterior vertebral bady surfaces; marked alteration of intervertebral disk space between C5 and C6; and dislacatian af interarticular facets.

Divergence of the posterior neural arch of the atlas so that it appears tilted toward the occiput, and increased distance between it and the spinous process of the axis, suggests dislocation or fracture-dislocation of the atlas on the axis. Study of the base of the odontoid with respect to the body of the axis is of real import. In hyperextension or hyperflexion fracture-dislocations of the atlanto-axial joint where the fracture has occurred through the base of the odontoid, the odontoid will maintain an intimate relationship to the anterior ring of the atlas, following the atlas in displacement by virtue of an intact transverse ligament (Fig. 4).

The open-mouth view is essential to complete roentgenographic study in cervical spine injuries. We have encountered no great difficulty in obtaining this view. For the examination to be satisfactory, the odontoid must be adequately seen and the facet joints between atlas and axis adequately displayed. Alteration of either joint must be interpreted, since unilateral dislocation of these joints can be identified accurately only on this examination.

The anteroposterior views may contribute valuable information. A systematic appraisal of the constituent parts of the vertebrae is essential. Vertebral height of the bodies is analyzed. Study of the intervertebral disk space, especially laterally, in the area of the uncovertebral joints where decrease in height of one side of the disk space and uncovertebral joint may indicate a rotary type of dislocation, with dislocation or fracture of the facet joint on the side on which the narrowing has occurred. Fractures of the posterior neural arch components are occasionally better visualized on the anteroposterior than on any other views. Longitudinal vertebral body fractures have been observed only on the anteroposterior views in our cases.

The oblique or facet studies in stereo are essential to exact identification of interarticular facet relationship. It is not necessary to move the patient to acquire these examinations. By altering the line of the roentgen tube and position of the x-ray cassette so that the x-ray penetrates the neck at an angle of 45 degrees from the standard anteroposterior tube, posterior to either right or left, and placing the cassette vertical to the tube, interarticular facet dislocation or fractures with interference in the normal

Fig. 4—Dislocation C1 on C2. Note that the neural arch of C1 approached occiput and diverged from C2; and that the odontoid is widely separated from anterior ring of C1.

intervertebral foraminal size or configuration can be seen on these views. In addition, where dislocation exists, this may be manifested in disturbed uncovertebral joint relationship due to facet dislocation.

In the event that the above roentgenograms are interpreted as normal, dynamic lateral flexion and extension films are obtained. Through motion, occult subluxations may be identified or break in a normal rhythmical line of motion may suggest acute injury to an intervertebral disk unassociated with fracture or dislocation.

In some injuries, the advent of cinemaradiography has already proven of benefit in our experience. In the future, such examinations will find increasing application in injuries of the cervical spine.

The following cases serve to illustrate some of these errors which may be made. This presentation is made in the hope of avoiding their repetition.

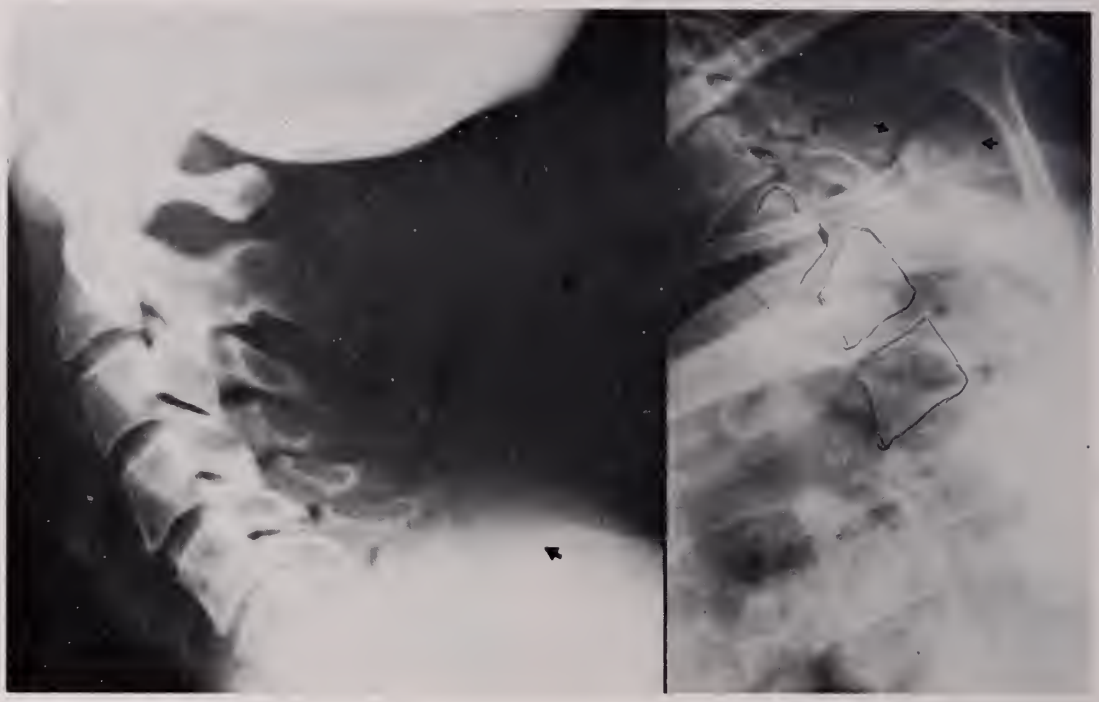

Fig. 5a and b—Case 1. Roentgenograms at time of injury were reported normal but did not show cervicodorsal junction; (a, left) the spinous process of C7 is posterior; (b, right) with one arm extended and the other arm at side with traction applied, roentgenograms provide excellent demonstration of a fracture-dislocation of C7 on D1.

Inadequate Visualization of Cervicodorsal Junction. *Case 1.* A 44-year-old man was seen because of complaints of pain in his neck and both hands following an injury he had sustained six weeks previously. At the time of the mishap, he was operating a motor boat, at dusk. He stood up under a low bridge, striking the top of his head on the underside of the bridge. He experienced severe pain in his neck which shot down the radial sides of both hands. He consulted a surgeon the next day and had x-ray studies which were reported normal. After six weeks of treatment with heat and massage plus cervical traction, his symptoms did not improve. His hand and arm pains were very distressing and were associated with progressive weakness and dysfunction in both hands.

Examination revealed distinct weakness along the C7, C8 and T1 nerve root distributions bilaterally with atrophy of the intrinsic muscles of both hands and hypalgesia along the C7–C8 dermatoma distribution bilaterally. He had brought with him x-ray films which had been made at the time of injury. These were simply inadequate, not revealing the cervicodorsal area. The attending physician believed he probably had a C7–D1 dislocation on the basis of examination and insisted on current x-ray studies which revealed the cervicodorsal junction properly (Fig. 5a and b). They showed a distinct fracture-dislocation of C7 on D1 with neural arch fracture of C7.

Case 2. A 34-year-old man was seen because of complaints of persistent pain in his neck accentuated by motion and paresthesia in his right thumb and index finger since an auto accident two months previously. The accident occurred as he was driving a truck which was struck from the side. The truck rolled over twice. He did not lose consciousness and was able to get out of the cab without assistance. He had immediate neck pain and numbness in his right index finger. He was hospitalized for 10 days. X-ray studies were reported normal. Because of increasing discomfort and failure to respond to heat, massage, and cervical traction, new x-ray films were made. These showed a distinct fracture-dislocation of C6 on C7. The initial x-ray studies, made at the time of injury, were again not adequate and allowed only visualization of C5 (Fig. 6a and b).

Case 3. A 58-year-old man was admitted directly to the hospital with severe neck, arm, and upper back pain following an auto accident. The car which he was driving had been literally overrun by a large auto-haul truck trailer on an expressway. The truck had flattened the back half of the patient's car, but the front bumper of the truck had stopped just behind the front seat.

Examination revealed a husky, short-necked, stocky, well-muscled man with tenderness over the lower cervical and upper dorsal area. Distinct C7–C8 nerve root weakness and hypalgesia were present. Cervical and dorsal spine roentgenograms were ob-

Fig. 6a and b—Case 2. Roentgenogram (a, left) at time of injury failed to show lower cervical vertebrae but was regarded as normal. The film (b, right) made two months later shows a fracture-dislocation on C6 an C7.

tained and revealed minimal compression of D4 and inadequate visualization of the cervicodorsal junction. Although a definite cervical fracture could not initially be identified, it was the impression of the neurologist and the author that a fracture-dislocation in the lower cervical area must be present to account for his neurological findings.

He was placed on a Foster frame with Vinke skull tongs traction and had more than a dozen attempts at trying to achieve satisfactory x-ray examination. His short, thick neck and massive shoulders made the task most discouraging. Finally, 10 days after admission, adequate x-ray films were obtained by exerting downward traction on one arm with the other extended over the head with traction applied also on that arm. These films revealed a fracture-dislocation of C6 on C7 (Fig. 7).

The important point in this problem was the need for persistence in achieving proper roentgenograms.

Each of these cases demonstrates clearly the need to see the cervicodorsal junction on x-ray studies. Persistence as emphasized in the last presentation may be required with the roentgenologist using a variety of techniques to obtain proper exposure of this area; e.g., depressing the shoulders by exerting traction on the arms, leaving an arm along the side and placing the other arm over the patient's head, or by the use of laminography.

Improper Interpretation and Lack of Oblique Roentgenograms. *Case 4.* A 32-year-old woman was seen with complaints of severe neck and arm pain which had begun seven months previously. At that time she had received a number of physical beatings from her husband. On more than one occasion he had picked her up by her head and thrown her against the wall. She had severe pain after the last of these bouts, but she did not consult a physician until a month or so later because of fear of her husband. X-ray studies at that time were reported normal. They were reviewed and were of poor quality, containing only anteroposterior and lateral views.

Examination revealed a small woman with a mild torticollis, the chin slightly tilted to the left. There

Fig. 7—Case 3. Right frontal oblique clearly shows facet dislocation of C6 on C7. Note alteration in intervertebral foramen at point of dislocation.

was tenderness over the posterior cervical area. No neurological changes were present in the arms or legs.

Roentgenograms revealed slight divergence of the spinous processes between C5 and C6. Oblique views showed distinct unilateral interarticular facet dislocation between C5 and C6 on the right side.

Improper Evaluation of Atlanto-axial Relationships. *Case 5.* A 64-year-old carpenter was seen because of complaints of pain in the suboccipital area since an injury he sustained 10 months previously. He had just finished installing a stairway in a new house and stepped back to view his work, striking the back of his head on a beam. Since that time he had complained of pain which failed to respond to heat, massage, and manipulations. X-ray films made shortly after injury were reported normal. The only way in which he found pain relief was by using a collar, cradling his head in his hands, or by lying down.

Roentgenograms were obtained, revealing a severe dislocation of C1 on C2, with forward displacement and a fracture through the isthmus of the odontoid (Fig. 8a and b).

Misinterpretation of lateral roentgenograms in children has led to severe overtreatment of the normal child for an alleged fracture.

Other Severe Injuries. *The presence of other severe injuries, especially to the head and face, has led to cervical fractures being simply overlooked, by not being considered.*

Fig. 8a and b—Case 5. Ten months prior to this examination, patient bumped back of his head with immediate pain and discomfort. His pain did not respond to heat, massage, and gentle manipulation. Fracture-dislocation of C1 on C2 with the odontoid broken from body of C2 and carried forward with C1 (a, left). Following operative relocation, wiring and fusion of C1 and C2 (b, right).

Fig. 9—Case 6. A 32-year-old woman with severe facial injuries with bilateral temporomandibular dislocations, fractures of the maxillae and mandibles. Complaint of severe neck pain prompted the radiologist to obtain this view. There is a hyperextension fracture-dislocation of C2 on C3.

Case 6. A 32-year-old woman was admitted to the hospital following an automobile accident in which the car she was driving hit a tree. She exhibited severe maxillofacial deformities, was bleeding profusely from her nose and mouth, and an emergency tracheotomy was done to establish a clear airway. Blood loss was replaced by transfusion with whole blood. She was taken by stretcher to diagnostic radiology complaining bitterly of severe suboccipital pain. She was examined by a radiologist who believed that in view of the severity of facial fractures, cervical spine injury had to be strongly suspected. The clinician had overlooked this possibility and had concentrated only on the facial injuries. Roentgenograms revealed bilateral temporomandibular dislocations, bilateral fractures of the maxillae, bilateral mandibular fractures, and a hyperextension fracture-dislocation of C2 on C3 (Fig. 9).

Case 7. A 9-year-old boy (Fig. 10) was seen with a fixed cervical torticollis. Six weeks previously he had been struck down by an automobile while running across the street. He was brought directly to the hospital unconscious and remained so for more than three weeks. He had a large area of skin loss

Fig. 10—Case 7. Because of persistent torticollis following head trauma, roentgenograms of atlanto-axial joint were made.

over the occiput and had received symptomatic treatment during his period of unconsciousness. With recovery of consciousness and resumption of walking he displayed a very mild spasticity, more marked in the lower extremities, with slight ataxia. Because of the torticollis, the neurosurgeon had repeat x-ray films made of the cervico-occipital junction. These revealed dislocation of C1 on C2. Of real interest is the fact that in retrospect skull x-ray films made during his period of unconsciousness showed the area of dislocation.

Both of these examples clearly indicate the need to consider the possibility of cervical spine injury in association with severe head or facial trauma.

Summary. Fractures and dislocations of the cervical spine have been "missed" or overlooked and normal anatomical variations misinterpreted on roentgenographic examination. These errors may be overcome by the following:

1. Proper roentgenographic evaluation of the cervical spine which must include lateral, anteroposterior, oblique, and open-mouth views of this area. Good quality films are extremely important. Visualization of the cervicodorsal junction is mandatory.
2. A means for careful analysis of the roentgenograms is presented and has been most helpful in avoidance of errors in diagnosis.
3. In the multi-injured person, especially those with maxillo-facial or head trauma, the possibility of neck injury must be strongly suspected.

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Treatment of Poisonous Snake Bites

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■ **CASE REPORTS.** *Case 1.* The following is taken from an 1853 medical journal:[1] "I was called a few days since to visit a negress, some 8 miles from my office, who had been bit by a large rattle-snake. I saw her eight hours after the wound had been inflicted, which was on her ankle. I found the patient deathly sick; cold rigors running over her; pulse 120, small, quick, and thread-like; the entire left leg was swollen to twice its normal size; in a word, I thought she was moribund. She complained of no pain in the affected limb, and even insisted that she had not been bitten. I commenced giving her corn whiskey by the gill, and pushed the remedy until she had taken two quarts within twelve hours, when discovering some symptoms of inebriation, it was discontinued. In the meantime I applied warm emollient poultices to the wound, after having applied a cupping glass for one hour. In three days this negress was well and at her usual labor. . . . She took no medicine save the whiskey, and on the second day a dose of Epsom Salts.

"The question here presents itself, would the usual remedies have been attended with success in this case? Had I not considered her in a moribund condition, she doubtless would have been treated, not empirically, but scientifically. I will remark, however, that this is the fourth case that I have treated successfully with corn-whiskey, occurring from the poison of venomous reptiles. I had oftentimes seen ardent spirits recommended in snake bites, prior to my having prescribed it. My confidence in the remedy never was fully established until witnessing a rash act of a man while in a beastly state of inebriation. He caught a large rattle-snake and held it notwithstanding he was bit several times, until the snake becoming so greatly incensed bit himself, which soon relieved it from its confinement. The reptile speedily died. The man never complained of the least pain or uneasiness."

Case 2. A 31-year-old woman was seen in the emergency room of Duke Hospital, Durham, N. C., on Sept. 18, 1963, with a history of snakebite on the right ankle approximately one-half hour previously. She had been in good health until being bitten by the snake, which was identified as a copperhead.

On being seen in the emergency room, the patient appeared to be in no distress except for minimal pain and swelling in the area of the bite. Blood pressure was 120/70 mm. Hg., hematocrit reading was 34% at the time of admission and an hour later.

A tourniquet was immediately placed around the right thigh, and ice packs were applied to the right ankle and foot. About an hour after the patient was admitted, an incision was made in the area of the bite. Two ampules of polyvalent antivenom were given intravenously. Vital signs remained constant.

The patient was admitted to a surgical ward, where a sphygmomanometer cuff was placed around the right calf, inflated to a pressure of 15 mm. Hg., and pressure was maintained for 24 hours. Ice packs were placed around the right ankle and foot, and these were continued for three days. On the second hospital day the patient was transferred to the medical service and was given 20 mg. of prednisone, twice daily. On the third hospital day the patient complained of pain in the right calf and thigh. Thrombophlebitis was suspected, and the patient was given 100 mg. of heparin daily.

Eleven days after admission, the patient complained of pain in the left lower abdominal quadrant. Surgical and gynecological consultations were obtained, and the diagnosis of a ruptured corpus hemorrhagicum was entertained. This was confirmed on the following day at laparotomy when approximately 50 ml. of free blood was removed from the abdominal cavity. The left ovary, which contained a ruptured hemorrhagic cyst, was removed. The patient underwent an uneventful postoperative course, her drugs were tapered and discontinued, and she was

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Publication of the article has been authorized by Dr. Bayard Carter of Duke University Medical Center and by Dr. Robert Hickey of the University of Wisconsin Medical Center.

discharged nineteen days after admission to the hospital.

As the above cases illustrate, (1) snakebite is a dramatic medical emergency, (2) it is usually not fatal regardless of the therapy employed, and (3) in emergent situations the physician may often abandon the luxury of scientific therapy in favor of measures in which he has greater confidence. The occasion is indeed fleeting, experience fallacious, and judgment difficult.

Statistics. About 14 fatal cases of ophidiasis occur each year in the United States.[2] Although the total number of cases in this country is not known, in those states in which records are kept the mortality of this condition is about 2 per cent,[3, 4] so that by extrapolation one can infer that there are about 700 cases of poisonous snakebite per year in this country.

Almost all snake bites occur on the limbs of the victims.[4] More deaths occur from this condition in the first 10 years of life than in any subsequent decade of life.[2] About 85 per cent of deaths due to snakebite occur more than five hours after the victim has been bitten.[2]

Thus in a typical situation the physician is dealing with a child who bears on his arm or leg a lesion which is potentially lethal but which, statistically considered, offers a good chance of survival. There is time for adequate evaluation of the patient's status and for careful planning of therapy.

Pathologic Physiology. In terms of toxicology, there are two types of poisonous snakes in the United States: the coral snake, which produces a primarily neurotoxic venom, and the pit vipers, all of which produce essentially the same type of venom containing many toxic constituents. Pit vipers include rattlesnakes, copperheads, and cottonmouth moccasins.

The following substances have been identified in pit viper venoms:

1. Lecithinase: This acts by breaking off one saturated fatty acid from the lecithins in the plasma, producing a lysolecithin which destroys the membranes of erythrocytes and attacks capillary endothelium. This results in hemolysis, ecchymosis, and pulmonary hemorrhage.[5]

2. Hyaluronidase: This promotes the spread of venom through tissues without regard for patterns of lymphatic drainage.[6, 7]

3. Digestive Enzymes: These contribute to necrosis at the site of the bite.[6]

4. A substance which removes fibrinogen from the victim's blood, rendering it incoagulable. This substance behaves like thrombin but is not inhibited by antithrombin. In one case of rattlesnake bite carefully studied, blood drawn from the patient three hours after the bite had occurred would not clot. Coagulation studies revealed afibrinogenemia, which resolved spontaneously within 24 hours.[8]

5. A substance which causes release of histamine from organs exposed to the venom. This may be one of the above substances or an additional factor.[6]

6. Other proteins which are in themselves toxic without enzymatic action or intermediate products.[9]

The above is only a partial description of the composition of pit viper venom; no such venom has ever been completely analyzed. In addition, it should be emphasized that the composition of a snake's venom varies greatly from time to time and among individuals of the same species.[10] The amount and concentration of venom received by a snakebite victim also vary greatly.[11] Thus the severity of a given case of ophidiasis cannot be predicted beforehand.

Diagnosis. Certain points in the patient's history are of particular importance. The offending snake should be secured and identified, but this must not delay treatment. Knowing the amount of time elapsed between occurrence of the bite and contact with the physician helps to determine therapy.

The status of the patient dictates therapy; in the absence of physical signs of envenomization no specific therapy is indicated despite a substantiated history of a bite by a poisonous snake.[11]

1. Coral snake bites: The bite of the coral snake produces minimal local pain and swelling, and there are no characteristic fang marks at the site of the bite.[12] Signs of serious envenomization are cranial nerve

palsies and central respiratory paralysis, the latter being the mechanism of death in fatal cases.[13]

2. Pit viper bites: The characteristic feature of a pit viper bite is the puncture wound made by the snake's fang; often there is a pair of these punctures. If an appreciable amount of venom has been received by the patient, pain at the site of the bite is marked. Characteristically, swelling of the bitten part begins within a few minutes after the incident, and ecchymosis follows in severe cases. The swelling proceeds proximally, without following patterns of lymphatic drainage and unhindered by tourniquets.[7]

Systemic symptoms in severe cases include those of shock, with hypotension and tachycardia, plus nausea, vomiting, dizziness and hemoptysis.[8] Some of these effects may be due to hemolysis, others to release of histamine, others to capillary damage, and others to nonspecific toxicity.[5]

Treatment. *1. Coral snake bites:* Contrary to popular belief, the bite of the coral snake is not uniformly fatal. The paralysis of the respiratory center is transient; and if respiration can be maintained by artificial means for one or two days, recovery should ensue.[12] A specific antivenom is not marketed in this country but can be obtained from the manufacturer in Brazil in a few hours, and is apparently effective in treating this condition.[14]

2. Pit viper bites: Victims of pit viper bites should be hospitalized, and blood should be drawn for typing and cross-matching immediately since subsequent hemolysis and accumulation of abnormal substances in the blood may make this impossible at a later time.[8] In addition, hematocrit reading, clotting time, prothrombin time, and bilirubin levels should be determined immediately and at frequent intervals. Vital signs should be followed closely.

The author would like to make a plea for objective evaluation of the patient's status by the above laboratory determinations and by objective measurement of the amount of swelling in the affected limb. Such statements in the literature as "the leg was markedly swollen" or "the swelling had perceptibly increased" are not as convincing or accurate as serial measurements of circumference made with a tape measure at fixed points on both the affected and contralateral limb.

Several time-honored local measures for the treatment of snake bite are still being recommended, both as first-aid measures to be performed by the layman and as therapy to be given by the physician. These include tourniquets, incision and suction of the bitten area, and cooling the affected limb.[15]

Although snake venom may be absorbed by blood and lymphatic channels, its spread is primarily due to its hyaluronidase content and is unaffected by tourniquets. In one reported case of rattlesnake bite incurred on the hand, swelling progressed up the arm despite a tourniquet to involve the shoulder and pectoral area, and subsequently spread down the side of the thorax as far as the iliac crest.[7] In a reported case of snakebite incurred on the ankle, swelling and ecchymosis proceeded up the leg to involve the abdominal and thoracic walls, worse on the contralateral than on the ipsilateral side of the bite.[16]

Advocates of tourniquets in the treatment of snakebite recommend that the tourniquet be applied so loosely that one can readily pass a finger under it.[17, 18] This is as tight as the average necktie or wristwatch band is normally worn, and seems to the author to be the equivalent of no tourniquet at all. In view of this, and the fact that an improperly applied tourniquet may do more harm than good,[19] it is recommended that tourniquets be abandoned in the treatment of snakebite.

Incision and suction of the bitten area are still advocated by many authors but have recently been criticized. Numerous animal experiments have been conducted and the evidence seems to indicate: if incision and suction are performed immediately after injection of venom, and suction is maintained continuously for one-half hour thereafter, an appreciable amount (up to about 40%) of the injected venom can be removed from the animal.[20] Any delay before instituting these procedures decreases the amount of venom which can be removed from the wound, and applying suction beyond one-half hour after the venom has been injected is of no value.[21, 22] Thus incision and suction may be useful first-aid procedures, but probably are not helpful by the time the patient is seen by a physician.

Cooling the bitten limb was advocated and practiced for a short period before its ineffectiveness[23] and potential dangers[24] became known. In a comparative study involving injection of rattlesnake venom into groups of dogs which were subsequently treated by various methods, it was observed that animals receiving lethal doses of venom uniformly died when treated with local hypothermia. Animals which survived after receiving sublethal doses of venom and were treated with local hypothermia developed necrosis of the injected limb which was more severe than that seen in any other group of animals. The authors remarked: "It would appear that localization of venom by cold is definitely deleterious."[22] It is still favorably mentioned by some current authors,[15] but will probably soon pass into oblivion which it deserves.

Steroids have been used in the treatment of pit viper bites. However, in view of the response of the medical profession to the discovery and availability of steroid hormones, it would be surprising if they had not been tried for this condition. Their dangers in the treatment of snakebite have been well demonstrated[25] and are apparently known to all but a few physicians. Steroids are indicated only in the treatment of serum sickness which may result from the administration of antivenom.

Antihistamines occupy essentially the same place as steroids in the treatment of ophidiasis.[26] In view of the liberation of histamine from organs experimentally perfused with pit viper venom, one might expect a beneficial effect of antihistamines on snakebite victims. However, antihistamines have been shown experimentally[27] to enhance the toxicity of pit viper venom. They are apparently indicated only in the treatment of serum sensitivity reactions when steroids are for other reasons contraindicated.[8]

In a comparative study of 55 human cases of snakebite, the 9 patients receiving antivenom alone had no mortality and had an average hospital stay of 2.8 days.[28] Twenty-five patients receiving antivenom plus incision and suction had an average hospital stay of 3.8 days, and 21 patients treated with antivenom, incision and suction, and steroids had an average hospital stay of 4 days. There was no selection of cases in these groups.

Specific therapy of pit viper envenomization consists of administration of antivenom.[29] Currently available anti-venom is prepared from hyperimmune horse serum and is effective against bites of rattlesnakes, cottonmouth moccasins, and copperheads, as well as some Central American and Asiatic poisonous snakes.

Administration of antivenom should be preceded by appropriate skin and conjunctival tests used before administration of any derivative of horse serum. Instructions concerning sensitivity tests accompany each package of antivenom obtained from the manufacturer.

In general, the physician should "play by ear" in determining the appropriate dose of antivenom; that is, the amount of antivenom administered should be proportionate to the severity of symptoms, and additional antivenom should be given if symptoms increase in severity, persist, or recur after administration of the initial dose. The initial dose is between 1 and 10 vials of antivenom.

The initial dose can be injected intravenously, intramuscularly, or subcutaneously in a "ring" around the bitten area in advance of the spread of the swelling. Injection of antivenom into an area already swollen by snake venom is apparently ineffective, and antivenom should never be injected into a digit. The initial dose should probably be divided between local subcutaneous and systemic parenteral injections.[30]

Prevention of infections, pyogenic and clostridial, is essentially the same in cases of ophidiasis as in other wounds.[16] The indications for tetanus and gas gangrene antitoxins in this condition do not differ from those prevailing in other cases of trauma.[31] However, secondary pyogenic infection in a snakebite often occurs[16] and many physicians advocate prophylactic antibiotic administration.[11]

No therapeutic plan will obviate the necessity of frequent and careful evaluation of the patient's status. The physician should in particular watch for persistence or increased severity of the original symptoms, signs of serum sensitivity, or infection. Serial laboratory determinations mentioned above are advised. Transfusions of whole blood may be needed.

Although ophidiasis is a very rare cause of death in this country, it is a situation which is frequently encountered in many types of medical practice and concerning which the physician is expected to have con-

siderable erudition. However, the experience of the average medical center with this condition is meager, prohibiting extensive controlled studies. Thus much that is false has been taught about snakebites, and many mistakes have been made in treating its victims. A cooperative study involving enough medical centers to provide statistically significant numbers of patients is needed for evaluation of the various therapeutic measures. Until such a study can be made, it is advised that measures of questionable justification be abandoned in favor of the most specific and least complicated form of therapy.

Summary. Various specific and nonspecific therapeutic measures for the treatment of ophidiasis have been discussed. Two cases have been presented which illustrate the differences in technique and the similarities in thinking of physicians separated by a century in the treatment of this entity.

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Concerned with smoking and heart disease is a leaflet available free of charge at the Wisconsin Heart Association, 205 West Highland Avenue, Milwaukee. Some 60,000 men die prematurely in the United States each year of heart attacks associated with cigaret smoking, according to the leaflet. This number is approximately equal to the estimated number of men who will die prematurely from lung cancer and other diseases associated with smoking, the association states.

In question and answer format, the pocket-sized leaflet briefly summarizes some of the research on effects of cigaret smoking on the cardiovascular system.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

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Case Presentation.* The patient, a white 58-year-old man, was first admitted to the hospital on Mar. 20, 1959, having lost consciousness that morning. Two days before he became "aphonic" while dining. He slept well that night and apparently felt well the following day. On the day of admission, however, he became unconscious while at work and came home. His physician was called, and the patient stated that he had a severe headache and wished to be hospitalized.

He said at this time that he had never had hypertension, but "collapsed" for about 15 minutes during a business interview two years before admission. He knew of no cardiac disease, diabetes, or renal disease. He had not vomited, and no history of visual defects or convulsions could be elicited. In the month before admission, however, he had lost 20 lbs., which he attributed to anorexia of unknown cause. He complained of loss of equilibrium and had the sensation that "things were turning around him." He had frequent earaches.

He stated that he had an "ulcer," apparently asymptomatic at the time of admission. He complained of muscular weakness and atrophy, duration not recorded. He also complained of some scaling and redness of the skin about his head from time to time. He had had scarlet fever at the age of two years and a mastoidectomy at three years.

His father, mother, and one brother died of cancer, and one sister was dying of cancer at the time of admission.

Physical examination revealed the patient to be "somewhat dazed." He showed nystagmus of a horizontal type, with the slow component questionably to the right. His thorax was somewhat increased in its anteroposterior diameter. His blood pressure was 100/60 mm. Hg. No cardiac abnormality was found. The remaining physical examination was noncontributory.

An examination later that day revealed a blood pressure of 80/50 mm. Hg. seated, and 90/60 mm. Hg. prone. This hypotension persisted, and a history of episodes of numbness in various parts of the body was elicited by a neurological consultant. Transient aphasia occurred, and the patient was somewhat unstable emotionally, weeping easily, and having fits of sudden anger which he could not explain.

Laboratory studies, on admission, showed a hemoglobin level of 12.8 Gm. per 100 ml.; hematocrit reading 42%; white blood cell count 5,800 per cu. mm., with 42 lymphocytes. The fasting blood sugar was 100 three days after admission, postprandial blood sugar was 123 six days after admission, and the total cholesterol level was 115 mg. per 100 ml. A Kepler test gave a ratio of 6. The excretion of 17-ketosteroids on three different occasions was 14.2, 10.8, and 13.5 mg. in 24 hours. The stools were positive for occult blood on two occasions, and negative on two occasions. A glucose tolerance test gave the following values: fasting 88, one-half hour 131, one hour 185, two hours 197, and three hours 160 mg. per 100 ml. The urine was negative for sugar throughout.

X-ray studies at this time were noncontributory. He improved with bed rest and was discharged from the hospital on Apr. 6, 1959.

The patient came to the hospital again on July 5, 1959, complaining that "he could not figure well." This complaint dated from his first admission, and he stated that he felt that he was generally not as capable mentally as he had been. His history was somewhat confusing, but he mentioned stiffness of his back and abdomen, weakness, dizziness and anorexia, a hematoma on the tip of his tongue and four welts on the anterior aspect of his left forearm the day before admission. He was cooperative at this time, but unable to give a good history.

Review by systems revealed that he was constipated. He had been given corticosteroids because of his hypotension and war-

* From Columbia Hospital.

farin sodium (Coumadin) for basilar artery syndrome.

Physical examination at this time revealed dry, cracked facial skin, with brown color; bilateral nystagmus; blurring of the temporal part of the right disk and of the nasal part of the left disk; a large hematoma covering the tip of the tongue; tenderness (degree not given) of his lower abdomen; a hematoma 5 cm. in diameter on the medial aspect of his right thigh; two smaller hematomas on the right knee. His blood pressure was 126/76 mm. Hg.

Laboratory findings revealed that he was mildly anemic, but the blood cells were essentially normal. His prothrombin time was reported as less than 5% on July 6, but the next day it was up to 25%. He had some electrolyte deficiency, the electrolytes being just on the low side of normal.

X-ray studies of the skull, chest, and cerebral angiogram were within normal limits. He continued a fluctuating course of orientation and disorientation. The patient was discharged without improvement on Aug. 9, 1959.

The patient's final admission was Sept. 6, 1959, with bilateral pulmonary dullness at the bases and bilateral rales. His blood pressure at this time was 80/60 mm. Hg. He was semi-comatose. His temperature was 103 F., axillary. He was obviously in a terminal illness, and he died the next morning after admission. No laboratory or x-ray studies were done during this admission.

Clinical Discussion. *Dr. John O. Chamberlain:* There are, as all of you know, many things that are left unsaid in this protocol. I will start by asking Doctor Coverdale to discuss any of the x-ray films which are available.

Dr. P. J. Coverdale, Jr.: There were arteriograms, a pneumoencephalogram, chest x-ray films, and a whole series of skull x-ray films. The skull x-ray film taken at the time of his first admission revealed no abnormal calcification and the pineal could be faintly seen in its normal location. It could not be definitely identified in the postero anterior exposure. The skull was normal. His chest x-ray films revealed that he had a rather small heart and a large, somewhat emphysematous thoracic cage. He had some peripheral calcified scarring, thought to be old tuberculosis, but the appearance of the chest was otherwise unremarkable. At the time of his second admission he had both arteriograms and a pneumoencephalogram done. In the arteriogram, in the lateral view, all of the vessels were normal in configuration and in caliber. In the anterior arteriogram, the left anterior cerebral vessels were noted to cross the midline and then return. This change was within the limits of normal variation.

The pneumoencephalogram showed the lateral ventricles to be at the upper limits of normal on each side and there was no displacement. The third and fourth ventricles were well visualized and were in the midline.

Dr. Daniel G. Santer: Is there any comment on the x-ray films?

Dr. Allan E. Kagen: I do not think the lateral ventricles were normal; I think they were enlarged.

Doctor Chamberlain: I have a few more questions before I consider the differential diagnosis. While I am not sure whether the spinal fluid examination was done, I suspect at least at the time of pneumoencephalogram this was obtained. Do we have that available to us, Doctor Ritchie?

Dr. Gorton Ritchie: On his first admission he had no spinal fluid examination. On the second admission his spinal fluid was said to be xanthochromic. There were 183 mg. per 100 ml. of protein. The erythrocytes numbered 116 and the white blood cells were 33 cu. mm., with 86 lymphocytes and 14 neutrophils.

Doctor Chamberlain: How about the pressure?

Doctor Ritchie: On July 17 the initial pressure was 340 mm. of water. With the removal of only 5 ml. of fluid, the pressure dropped to 180 mm.

Doctor Chamberlain: Several more questions are pertinent at this time. Do you know whether visual field studies were performed?

Doctor Ritchie: They were not.

Doctor Chamberlain: Electroencephalogram?

Doctor Ritchie: No.

Doctor Chamberlain: Serology?

Doctor Ritchie: Serology was negative.

Doctor Chamberlain: I suspect that with evidence of probable old tuberculosis, a primary complex at least on chest-x-ray film, we can suppose that the tuberculin skin

tests were positive. Do you have any definite evidence of that?

Doctor Ritchie: No.

Doctor Chamberlain: How about serum calcium?

Doctor Ritchie: No serum calcium was done.

Doctor Chamberlain: No clinicopathologic protocol would be complete without asking for the report on a lupus erythematosus phenomenon. Was this performed?

Doctor Ritchie: No.

Doctor Chamberlain: Was a random blood sugar specimen obtained at any time after the first admission?

Doctor Ritchie: Yes. His fasting blood sugar on July 6 was 94 mg. per 100 ml.

Differential Diagnosis. *Doctor Chamberlain:* This problem as presented can be attacked from several different angles, but as was apparent to the clinicians, it would seem to fall into two fields, a cerebral or a metabolic problem. Perhaps we might even combine the two as we go down the differential diagnosis and think of this case as though we were looking at it strictly from the cerebral side. Let's start off with the vascular possibility. This was a 58-year-old man in whom we had evidence of diabetes. We could be more certain of this if we had some assurance that he was eating reasonably well in the two or three days before the glucose tolerance test was performed. Even if he had not been eating well, this was such an abnormal glucose tolerance curve that one could at least say that he was a latent diabetic.

We can suspect, at least, that he probably was a latent diabetic because of his positive glucose tolerance test despite the absence of glycosuria, and this would, of course, bring up the possibility of arteriosclerosis of a more advanced degree than might be expected at age 58. Under that circumstance we could also go along with the clinicians' original thought, namely, that this was a case of cerebral arteriosclerosis with the basilar artery syndrome. In fact, they were so certain of it that they put him on anticoagulants. Were there any irregularities at all in the arteriogram to suspect arteriosclerosis from the pictures themselves in the absence of occlusion?

Doctor Coverdale: We did not note evidence of basilar artery occlusion on the arteriogram, but at the origin of the internal carotid there was, bilaterally, an area of minimal stenosis, and this was thought to be normal.

Doctor Chamberlain: To continue with possibilities of a vascular nature, this kind of picture could also come about from vasculitis, though rarely from such situations as lupus erythematosus. There were a couple of vague things mentioned in the protocol which may or may not be red herrings, such as the reddening and scaling of the skin about the head from time to time. This is about as vague as one can get.

Continuing along the vascular line, certainly a hemorrhage and/or hematoma, primary or secondary, could be the cause of this particular picture, at least in the second and third phases of this protocol. Not only did he have the potential with the probable arteriosclerosis which renders these people more susceptible to this, but the use of both steroids, which enhance vascular permeability and an anticoagulant, forms a combination which renders the individual more susceptible to hemorrhage. Was the circle of Willis well demonstrated, in your films, Doctor Coverdale?

Doctor Coverdale: Yes.

Doctor Chamberlain: And you were confident that there was no evidence of aneurysm in or about the circle of Willis?

Doctor Coverdale: Yes.

Doctor Chamberlain: Let us consider the metabolic aspect of the problems that can cause the cerebral as well as the general metabolic picture. The reason that I asked for the serum calcium was that there is a rare form of hypoparathyroidism with papilledema that can cause this cerebral picture. But, in the absence of a serum calcium determination I doubt very much that we could include that in our consideration of the problem. We move then into the hypoadrenal corticism picture which not only comes to mind because of the protocol but also obviously was a considerable problem to the clinician taking care of this patient. The patient had a number of things that were present both on examination and in the laboratory which suggested hypoadrenal corticism. He had hypotension, and this, I think, was the main feature which brought this to the fore and apparently to such a degree that in spite of the probable nondiagnosis, so to speak, of Addison's disease, they used steroids empirically in an attempt to raise the blood pressure. But, he did have hypoten-

sion, he had a brownish discoloration, apparently just to the skin of the face. There is no mention about scars or whether the brown pigmentation was more prominent over the knuckles, elbows, and so forth.

There was no further mention of this rash. Apparently there was never any dermatological opinion. This could be the skin change of collagen disease or could be nothing more than seborrhea. On the protocol it could be any one of a number of things. Regarding the headache, is there any more description of it? Where was it? Was it constant? How severe was it? When did it start? Did it come and go? Was it affected by position or straining? Or can you recall if there was no mention of it? If that is the case, we can go on.

Doctor Ritchie: I have no information as to that.

Doctor Chamberlain: Physical examination was reported as negative other than those things previously mentioned. I assume that the complete neurological examination was negative at all times.

Doctor Ritchie: That is correct.

Doctor Chamberlain: We will then continue with the arterial features and note that even the question of scleroderma and dermatomyositis comes up with some of the things that were mentioned here which could conceivably cause a picture not too different from this. It would be rare, but the mention of dry, thick, dark skin and stiffness of the back and abdomen brings up the possibility. Was this "stiffness" of the back and abdomen with reference to the muscles or was there "stiffness" of the skin?

Doctor Ritchie: It was stiffness of the muscles, as far as we could tell.

Doctor Chamberlain: The rash was limited strictly to the face. In this circumstance it is not too helpful, but it may be a clue to the problem. The muscle weakness, atrophy, weight loss, diminished electrolytes across the board, the lymphocytosis which was present in the hemogram, the small heart which showed on the x-ray films, constipation, the presence of old tuberculosis; all these things point toward the diagnosis of hypoadrenal corticism, either primary or secondary. If we take this brownish discoloration as a definite feature of the possible diagnosis of Addison's disease, it takes us a little bit away from secondary type because as a rule this hyperpigmentation does not occur in secondary type of hypoadrenal corticism. Doctor Ritchie included the Kepler's test which is a specific test for adrenal hypofunction in which the effect of water leading as well as the excretion of various electrolytes, including chloride and sodium, are measured. This was unequivocally positive. In the absence of nephritis, a figure like this can point towards the diagnosis of hypoadrenal corticism. There was no evidence here of nephritis. We are interestingly missing urinalyses. I take it that these were noncontributory.

Doctor Ritchie: These were noncontributory and were approximately normal throughout.

Doctor Chamberlain: I think with that information we can assume that he did not have nephritis and even though we hate to put much credence on one positive laboratory test, this strongly points to the diagnosis of hypoadrenal corticism. Other causes of such a low value, but rarely so, would be the presence of such things as a malabsorption syndrome or water intoxication, neither of which appeared to be the case. Again, on the positive and negative side were the diverse readings of the Thorn test which Doctor Ritchie explained. The first one in which the eosinophils before the ACTH were 263 and dropped normally and precipitously to 3 after the given period of time, is evidence for normal adrenal cortex. However, when it was repeated we get a diametrically opposed result, probably speaking more against the use of the Thorn test than the actual interpretation, in which he had 13 cells before and then after ACTH, 38. Right now, all we do is cross that test out. It is merely confusing. But, the thing that really is against hypoadrenal corticism, is the normal ketosteroid level. Granted that Addison's disease may, particularly in its early phases, have a low normal 17-ketosteroid level, it would be extremely unusual to have three different readings within the normal range as occurred with this patient. Were there any other steroid determinations later in the course of this illness?

Doctor Ritchie: No.

Doctor Chamberlain: So, we have both positive and negative evidence as to the question of Addison's disease. Actually, as we put them all together, we probably have more on the positive side than we do on the negative side, but the negative ones, namely these normal ketosteroids, are rather disconcerting

in the attempt to make a definitive diagnosis of Addison's disease, or hypoadrenal corticism.

Then we move on from the metabolic and the vascular, to the primary tumor, or brain tumor itself. We certainly have evidence to suspect that he had a brain tumor. Surely there was an elevated spinal fluid pressure. He had many clinical symptoms of a brain tumor: "black-outs" started apparently as much as two years before he really got in trouble. In the last year of his illness he had headaches. We don't have any description of the headaches, but at least we know that they were present. He had vertigo which could take his illness anywhere in the brain, from the eighth nerve to the cerebellum and medulla. The description does not point to its localization. He had earaches, he had nystagmus, he had changes in mood from weeping to fits of anger, and evidence of disordered thinking. He probably had a convulsion, too. This is not stated as such, but when he entered the hospital on July 5 he was confused, had stiffness of the back and abdomen with hematoma of the tip of the tongue and four welts on the anterior aspect of his left forearm. These findings certainly suggest that a convulsion may well have been what occurred to produce such a combination of findings. I take it that these four welts on the anterior aspect of the forearm were bruises, or isn't that what the term "welt" means in this instance?

Doctor Ritchie: This I do not know. That is what I found on the chart and there was no further mention made.

Doctor Chamberlain: There was no mention of an aura or anything like that which would help us in localization. He also had choked disks as evidenced by the blurring; and last, but surely not least, the presence of Doctor Steiner on this protocol, which brings me to think that the patient well may have had a brain tumor, or something directly related to the cranial vault.

Doctor Ritchie: That is a very good diagnostic point.

Doctor Chamberlain: The factors against brain tumor are some of the things that Doctor Coverdale brought out, even if we skip the fact that we were totally unable to find any abnormalities in the neurological examination. He had negative skull x-ray films. He had a negative angiogram. There is some abnormality of the pneumoencephalogram, with enlarged lateral ventricles. If we go along with the presence of a brain tumor, what kind of brain tumor are we dealing with here? Is it primary or secondary? About 20 per cent of brain tumors are secondary. We have a couple of things that might make us think that there might have been something amiss in organs other than in the brain itself as a possible source of metastatic tumor. The weight loss, of course, which is not specific, could go along with a carcinoma or tumor in the body. Was he a smoker? Carcinoma of the lung, of course, is the most common single entity sending metastatic elements to the brain and is responsible for about 40 per cent of all secondary brain tumors, followed by thyroid, breast, kidney, colon, and the like. He had constipation which again is not specific, but he also had blood in his stools which may point toward a real red herring, mainly carcinoma of the colon with metastasis to the brain. Was a colon x-ray performed, Doctor Coverdale?

Doctor Coverdale: No.

Doctor Chamberlain: Was a proctoscopic examination performed?

Doctor Ritchie: No, but in answer to your question regarding cigarettes, he smoked four a day.

Doctor Chamberlain: Then comes the question of tying the metabolic and cerebral problems together as we move on to the primary brain tumor. Needless to say, if we are looking at the cerebral aspects and we are also dealing with the possibilities of Addison's disease or hypoadrenal corticism, we think of the pituitary and its malfunction. As you all know, in pituitary insufficiency about the last of the secondary organs to go are the adrenals. What about his gonadal and thyroid status? Was this evaluated?

Doctor Ritchie: No.

Doctor Chamberlain: So we have no evidence of hypothyroidism. We have no evidence of hypogonadism, which would be very helpful in making this diagnosis; and the frequency of a secondary hypoadrenal corticism all by itself without evidence of hypothyroidism, and without evidence of hypogonadism, is rare. It does happen, but it is extremely infrequent. But craniopharyngioma and particularly chromophobe adenomas could conceivably cause such a picture. We do not have any calcification above the sellar region. We did not know the age

of the patient until this morning, but he was not a child so the possibilities of a craniopharyngioma are reduced significantly, but they could cause this particular picture. We don't have any erosion or enlargement of the sella and so forth which would go along with this. Now, a chromophobe adenoma, if we are talking about the pituitary, would probably be the most likely. Then we run through the list, namely, the cerebellopontine angle tumors, acoustic neuromas, the cerebellar hemangioblastomas, brain stem tumors, temporal lobe tumors, third ventricle tumors; they are all possibilities in this circumstance, but unlikely.

To summarize, it is my feeling that this patient likely had some degree of hypoadrenal corticism, either primary or secondary; that he probably had a space-occupying lesion, the first consideration being a brain tumor and he probably bled into this brain tumor. At least, we know that he was on warfarin sodium and steroid therapy which rendered him even more suspectible to hemorrhage. He went into this episode of marked hypoprothrombinemia, which coincided with the time that he got into significant trouble. He had xanthochromic fluid. So apparently he did have some intracerebral bleeding and most likely, this is into a tumor, so in summary I put this combination as my first and probably only thought, with these others as much less likely possibilities.

Doctor Santer: Thank you very much. Then your thought was adrenal insufficiency and a space-occupying lesion, probably primary tumor with hemorrhage, if I have summarized that correctly?

Doctor Chamberlain: Yes.

Doctor Santer: I think we should move along and let Doctor Steiner make any comment before we have any general discussion. Doctor Steiner?

Dr. Robert E. Steiner: I would like to start back at the beginning of this protocol. I think the first two paragraphs are somewhat intriguing. I would like to point out that the term "aphonia" is used; I think, by and large "aphonia" and "aphasia" are often used one for the other when they really should not be. Aphonia, of course, refers to some problem in the peripheral speech mechanism; a tracheostomized patient is aphonic. This patient reportedly became aphonic while eating. I will assume he did not aspirate something, although this is conceivable. On the day of admission, and this is also a little vague, he became unconscious while at work and then he came home. I assume he regained his consciousness before he came home. We are told later that he had a headache thereafter and that he was dazed. I shall assume the fact that he did not have a head injury at this point.

The concrete facts that we get in the beginning of the protocol include the fact that he had a fairly definite weight loss reported to be 20 lbs. in one month.

He also had the complaint of anorexia. Under his system review the first thing that was mentioned was loss of equilibrium and that he had frequent earaches. I think this combination of phenomena forces us to consider two possibilities here, one being ear infection with subsequent possible intracranial abscess. Abscess of the brain from ear disease is, by and large, in one of two places: either the cerebellum or cerebellopontine angle, or the temporal lobe. I think the other possibility to mention with this combination of sympoms is cholesteatoma.

Now we go on and find that he had an ulcer, apparently asymptomatic at the time of admission. I will make another assumption that this refers to an ulceration in his gastrointestinal tract, probably of peptic nature. I think this immediately must raise another possibility. Perhaps he did have an ulcer and perhaps this ulcer was malignant. This of course we do not know, but it is something for consideration and raises the question of metastatic intracranial tumor.

His muscular weakness and atrophy have no recorded duration. It is not inconceivable that this man had some long standing, primary, muscle atrophy type disease. I mention this only as part of a differential diagnosis. The redness and scaling of his skin around the head sounds somewhat like it might be a bit of redness on a "red herring" to me. I really cannot make much of that.

It is rather intriguing that his father, mother, and one brother died of cancer. I will restrain myself and not ask what kind. If they all died of multiple hemangioblastoma or reticulum cell sarcoma, or something of this sort, it might be of interest in this particular case.

Doctor Ritchie: They were not familial types of cancer.

Doctor Steiner: We continue the physical examination. He appeared "somewhat dazed"

and he had some nystagmus, the slow component questionably to the right. This rather chronic fixation on slow and fast components in nystagmus is, I think, perhaps a little overdone. I am not really sure in my own mind that the slow or fast component in nystagmus is that helpful at the bedside. Some other very common causes of someone who might be dazed with nystagmus would include alcohol or phenobarbital. We have no history of his taking medication, but it is not inconceivable. And, of course, the possibility of some cerebellar disease, or for that matter labyrinthine disease, must be considered. Labyrinthine disease would not necessarily make him dazed, however.

His blood pressure all through the protocol was on the rather low side. He was hypotensive, as we have already learned earlier, and he had an ulcer. We now have an ulcer in a man who is hypotensive and very weak, and the possibility of gastrointestinal tract hemorrhage has to be raised. The rest of his physical examination was noncontributory. Now we press on and find a couple of even more reduced blood pressure readings and then he described a history of episodes of numbness in various parts of the body. I think that type of rather vague symptom automatically must raise the possibility of something like multiple sclerosis. I think many people, in retrospect, once the diagnosis is finally made, have had these complaints of intermittent numbness here and there for very often a matter of a few years before the multiple sclerosis becomes obvious.

Now, we have transient aphasia, no longer aphonia, and a man who was emotionally unstable, wept easily and had fits of anger that he could not explain. Well, I think this raises a multitude of possibilities. It is not inconceivable that he was having some element of arterial insufficiency in his brain. Blood pressure was only 80/50 mm. Hg. at this point at least in a seated position. Other possibilities would be, of course, the brain tumor, probably in the frontal area; possibilities of a primary cortical atrophy of the Pick or Alzheimer type with these wide swings of his emotions; and, again, the not inconceivable possibility that there is some intracranial inflammatory disease going on. This could be tuberculosis or pyogenic in nature.

Now for the laboratory data. His white blood cell count was 5,800 per cu. mm., which is not very high, and he did have a lymphocytosis of 42%. Disregarding, or at least not placing much weight on the three 17-ketosteroid determinations of 14.2, 10.8, and 13.5 mg. per 24 hours, I will press on through two positive stools for occult blood and two negative ones which I think are probably run-of-the-mill in laboratory reporting. I do not know where in this course of events the steroids and warfarin sodium therapy was started. I will only assume for the moment that this was perhaps started when he left the hospital the first time or shortly thereafter. At any rate, the way it is presented here, I must assume that he had been on corticosteroid and warfarin sodium therapy prior to his return admission on July 5, 1959, when he complained that he "could not figure well," which apparently was one of his complaints all along. He was not confused enough at this time not to be able to complain of some stiffness of his back. He was again weak and again the dizziness returned. He had anorexia again, and this time he had some evidence of possible blood dyscrasia including a hematoma on the tip of his tongue and these "welts;" I certainly agree that I do not know what a "welt" is in this instance.

I would assume the most likely probability here is that the man reacted a little bit adversely to the warfarin sodium therapy. We find shortly thereafter that he had a prothrombin time of 5% the day after admission. With all these welts, hematomas, and the like, I think we must remember the possibility of a retroperitoneal hemorrhage. The man had a stiff back and stiff abdominal muscles. This raises the possibility, I believe, of blood dyscrasia including, of course, lymphomatous disease. I really cannot comment very much on this warfarin sodium therapy for basilar artery syndrome because I really do not find much prior to this in the protocol to pin this down as a definite basilar artery syndrome. He had dry skin; it was cracked and brown in color. This was in the month of July or August, so I assume this was not sun tan. I gather that it was brown enough in color to at least be worthy of mention in the protocol.

The possibilities now should include so-called Addison's disease and other possibilities such as hemachromatosis. The man was diabetic, as brought up before. He had nystagmus. He had some blurring of the tem-

poral margin of one disk and nasal part of another. We must take that at face value; I have no idea what it means. I am not sure who was interpreting this hemidisk blurring bilaterally. Perhaps the ophthalmoscope was a little dusty on one side. They also mention that it is blurring, with no actual mention of measurable papilledema. However, I will assume that it is some question of whether the man's disk margins were blurred.

There were a few more hematomas mentioned in the lower abdomen, thigh, and knee. Now his blood pressure was 126/76 mm. Hg. which from the beginning is about the most acceptable blood pressure he had recorded. However, he had also been on steroid therapy for some yet-undetermined length of time and perhaps this is the reason why his blood pressure had become a little more acceptable. As Doctor Chamberlain mentioned, with all these hematomas and the like in a dazed man with blurred disks, certainly the possibility of an intracranial bleeding episode, either subsequent to a seizure or without seizure, is a real one. A subdural hematoma, or intracerebral hematoma for that matter, must be considered. Getting on near the end, we find that his prothrombin time was sagging somewhat to about 5%. The next day it was up to 25%. I don't know why the difference in the two days. The possibility, of course, includes: (1) warfarin sodium therapy was stopped, (2) he was given some vitamin K, and (3) a possible laboratory error.

There has been no mention in the protocol of a pneumoencephalogram. Now that we know that he had one performed, I certainly agree with Doctor Kagen that those ventricles were large enough for me to call them definitely abnormal. I do not see much that would make me suspicious of any mass of significant size. It is certainly difficult to ignore a normal arteriogram and a normal pneumoencephalogram with the exception that the ventricles were a bit enlarged. I think, as Doctor Chamberlain pointed out, his chest x-ray film was of some interest, with a rather small heart demonstrated.

He was discharged unimproved on Aug. 9, 1959, and returned shortly thereafter with what appears to me most probably terminal pneumonia. He died very shortly thereafter. Putting all this together I think we have a man who had gastrointestinal symptoms; he had a normal but somewhat low-normal white blood cell count; he had a lymphocytosis; he was hypotensive; he had some pigmentation, at least on his face; and he had emotional lability with irritability. He had weakness, anorexia, weight loss, dizziness, and syncopal episodes. That sounds like a pretty good description of Addison's disease to me. I think he also had a problem of perhaps a little too much warfarin sodium, or at least a little too much reaction thereto, and I would like to stick my neck out and say I think he probably had Addison's disease. Oh yes, one other thing that we just learned this morning. He had a protein of over 100 in an xanthochromic spinal fluid. Is that correct?

Doctor Santer: That is correct.

Doctor Steiner: I think he had Addison's disease and a lot of the cerebral findings could be explained on this diagnosis alone, but I do not believe all of them. He had a lot of protein in his spinal fluid, a grossly yellow spinal fluid and symmetrically enlarged ventricles. If we assume that his Addison's disease was on the basis of tuberculous disease of the adrenals, then I think it is not inconceivable that he had a picture compatible with probably long-standing tuberculous meningitis. Now tuberculous meningitis attacking as it does chiefly the basal meninges, I would be a lot happier if someone had reported a couple of cranial nerve deficits here. Unfortunately, they have not, but if he did have a basilar archnoiditis subsequent to tuberculosis, I think he could have this tremendously high protein and he could have poor spinal fluid absorption, productive of his symmetrical borderline hydrocephalus. I think I will go out on a limb for tuberculous disease of his adrenals, Addison's disease and tuberculous archnoiditis, realizing that there are other good possibilities. If I may have another choice, may I ask the date of that arteriogram?

Doctor Coverdale: July 17.

Doctor Steiner: July 17 was shortly after his second admission. On the basis of that arteriogram I think I will not include the other strong possibility of subdural hematoma or intracerebral hematoma, but I think I will take as my second choice something perhaps a little more remote, a carcinoma of the gastrointestinal tract with metastases to the adrenals, and metastatic seeding of his meninges.

Autopsy Findings. *Doctor Ritchie:* The main feature at autopsy involved a retroperitoneal neoplastic mass which was limited superiorly by the diaphragm and extended down along the aorta to the bifurcation. Adrenal tissue could not be found either grossly or microscopically, but was replaced by tumor masses 9 cm. in diameter. The left kidney showed a subcapsular oval nodule 2 by 1 cm., which was obviously metastatic. In the brain there was invasion of the vessel walls by the tumor, especially in the meninges and in the choroid plexus. The microscopic picture of the tumor was that of infiltrating cells which were extremely irregular and simulated histiocytes with many giant cells, very reminiscent of Sternberg–Reed cells. The other areas of infiltration were in the epicardium, the lungs, the splenic sinuses, which contained a few tumor cells, the prostate, where there were emboli of tumor cells, and in the pars intermedia of the pituitary.

Figure 1 shows the tumor in one of the masses. You see in these vessels containing tumor cells why the tumor got into the blood stream and migrated. Figure 2 is a higher power picture of the tumor with large irregular cells, many of which had darkly-staining nuclei and irregular nuclei with large nucleoli. Figure 3 is a vessel in the brain and you see that the whole wall of the vessel has been infiltrated with tumor. I am sure if we had done serial sections of the whole brain we would have found some thrombi, but at any rate this process as we see it here interferes with the nutrition of the brain. There are also many lymphocytes and tumor cells in the meninges here.

This is the ultimate in Hodgkin's disease, clinically Hodgkin's sarcoma. The most important features in this case were the adrenocortical insufficiency (call it Addison's disease if you will, or perhaps it should be called Addison's syndrome, because it can be caused by many different agents), and the vascular lesion in the brain causing the hypoxia. Now as to the Kepler's test: it was described in 1941,[1] and as you have heard, it concerns the ability of the kidneys to dispose of large quantities of water and also tests their ability to conserve the sodium content of the blood. It is considerably safer than the so-called Cutler, Power and Wilder test,[2] which involves salt deprivation and may precipitate adrenal crises. The two Thorn tests were done, as you heard, and I think it was Doctor Chamberlain who said that this is a good argument against the Thorn test, because they are entirely conflicting and so far as we can determine made no sense in this particular case.

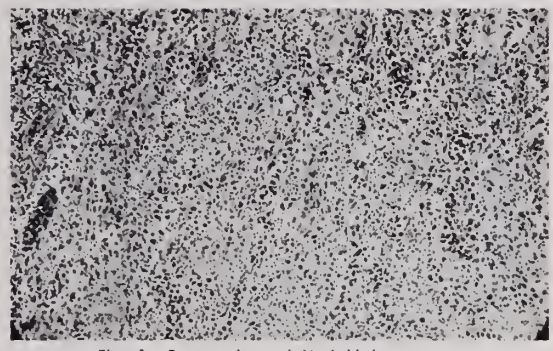

Fig. 1—Retroperitoneal Hodgkin's sarcoma.

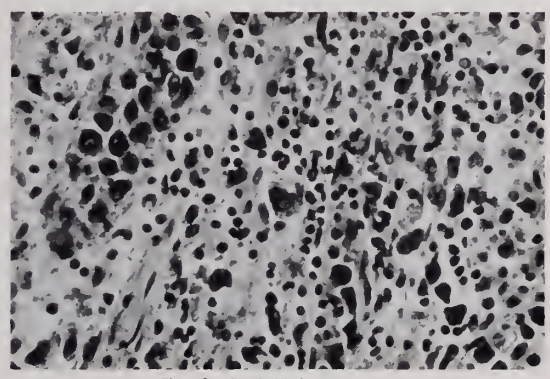

Fig. 2—Hodgkin's sarcoma.

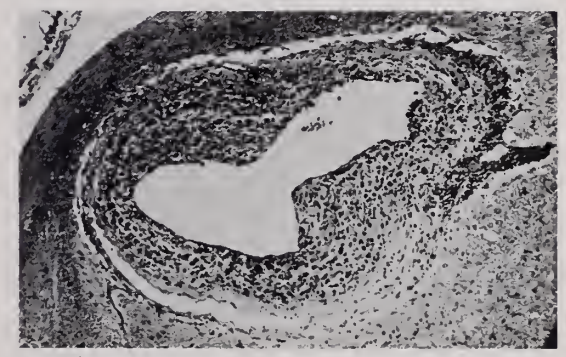

Fig. 3—Cerebral artery, with wall greatly thickened by neoplastic infiltration.

3321 North Maryland Avenue (11).

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RED CROSS 50-YEAR WATER SAFETY PROGRAM

This year the Red Cross Water Safety program is 50 years old. From the beginning of its safety programs, Red Cross has relied heavily upon the best medical and other professional consultants available to advise regarding each proposed change in program content and instructional practice.

The founder of the water safety program was Commodore W. E. Longfellow who fought a persistent personal battle against illness before founding this Red Cross program. Mr. Longfellow began his swim safety program in his native Rhode Island around the turn of the century, first on a local, then on a state level. Just as these limited programs began to show success, he was stricken with tuberculosis of the spine.

Immediately, Mr. Longfellow was placed in a plaster cast from hips to armpits and laid flat on his back indoors. Although he was immobilized, his interest in this lifesaving work was so great that he managed to continue supervision of the state-wide program by means of bedside conferences, the telephone and correspondence.

His illness, however, became more serious, and at one point the prognosis gave him no more than a month to live. Convinced that he was not going to improve remaining in bed the Commodore obtained permission to go out into the sunshine, where he reclined for hours in a big armchair. He kept himself occupied with ambitious plans for what he termed the "Waterproofing of Rhode Island" and he dreamed of the day when he would get back into the water.

By early spring the Commodore was walking occasionally to the doctor's office, and now and then giving an aquatic lecture, although still wearing his plaster cast. Early in the summer he had a lifesaving launch outfitted and with it toured the Narragansett Bay area, improving waterfront conditions and, with the aid of an assistant to play the part of the drowning victim, he staged reach-rescue demonstration.

By the end of the summer of 1908, the doctors put hinges on the cast and he was able to remove it for brief intervals to again enter the water. Supported by its buoyancy, he began to restore strength to atrophied muscles by taking mild swimming exercises.

At about this time the Commodore met several English millworkers in the nearby town of Graystone. They had just returned from England, bringing with them a new method of artificial respiration devised by Edward Sharpey Schafer, an anatomist at the University of Edinburgh. In those days barrel rolling was a common device for producing resuscitation on many beaches. When a formal method of resuscitation was used, the Sylvester method was taught.

Commodore Longfellow became an advocate of the Schafer prone-pressure method and immediately began to teach the technique. When critics claimed it was physiologically impossible to restore breathing in this manner, he went directly to the New York Academy of Medicine, requesting that it investigate the various methods of artificial respiration and report the findings. The Academy agreed and, substantiating Schafer's and Longefellow's claims, rendered an opinion that the prone-pressure method was indeed superior to any other then in use, both because of its effectiveness and ease of operation.

The Commodore soon set about to expand water safety activities nationally. The search took him to the American Red Cross, which was already conducting a national first-aid program. The Red Cross approved his proposed water first aid program and hired him in 1914 to head a water safety education program. His first step was to set up a Red Cross Life Saving Corps and to promote it nationally. He traveled from one community to another, attracting large crowds to his aquatic pageants where he "taught gently and entertained hugely." He also recruited the skilled swimmers in each place, trained them in rescue and resuscitation and organized them into a volunteer lifesaving corps that would carry on the work.

As the program developed, the emphasis gradually changed from training lifeguards to the goal of teaching the general public how to swim. For example, during World War II convalescent swimming developed as therapy for the war wounded and the ill in military hospitals. After the war convalescent swimming spread widely over the country as swimming for the handicapped, for crippled children as well as for war veterans. Many Red Cross chapters now conduct handicapped swim programs under medical supervision.

Upon recommendation of the National Research Council of the National Academy of Sciences, the Red Cross adopted the mouth-to-mouth (mouth-to-nose) method of artificial respiration for use on infants and small children in 1957 and on adults in 1959. Red Cross has taught artificial respiration to millions of persons through its lifesaving and first aid courses.

Another water safety activity of the Red Cross keyed to health needs is Swim and Stay Fit, a project launched in September 1961 as part of the late President Kennedy's physical fitness program. Purpose of the program is to encourage Americans of all ages to swim more and thereby improve their physical condition.

The melding of safety, health, and recreation aims for the welfare of the American people, so significant for the last 50 years, will doubtless continue as Red Cross Water Safety program enters its second half-century of service.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

The Hepatotoxicity of Drugs

By DEANE N. CALVERT, Ph.D.
Milwaukee, Wisconsin

■ THE TREMENDOUS increase in the numbers of new drugs appearing on the market in recent years has been accompanied by an increase in the incidence of various types of toxicity which result from the use of these drugs in human beings. The liver is one organ which has shown manifestations of toxicity with some degree of regularity. A recent conference was sponsored by the New York Academy of Sciences which took up this very issue. It will be the author's intent to attempt to summarize some of the results which were reported at this meeting[1, 2, 3] in tabular form. It is hoped such a table may be of some value for predicting and/or classifying hepatic problems as they appear among people who are on various of the therapeutic agents which have now quite definitely been shown to have hepatotoxic effects.

A description of the types of hepatic damage which have been observed is necessary for proper classification of the drugs. Table 1 summarizes such descriptions.

On the left hand side are the categories of hepatic injury and on the right hand side the cell type involved in the injury. The injury categories are toxicity and idiosyncrasy, with toxicity being further subdivided into direct and indirect. Those compounds which have direct toxicity are not going to concern us much here because they are mostly of toxicological interest. Compounds such as carbon tetrachloride and phosphorus fall into this category. The indirectly hepatotoxic materials are those which are believed to interfere with secretory or excretory pathways of the liver. In most instances these drugs produce a type of jaundice which can be clinically identified.

TABLE 1

Mechanism of hepatic injury (and jaundice production)	Hepatic manifestation
1. Toxicity of the drug — Direct / Indirect	1. Parenchymal cell damage 2. Hepatocanalicular damage 3. Mixed parenchymal and hepatocanalicular damage
2. Idiosyncrasy — hypersensitivity of the individual	

In order for a drug to fall into the category of being toxic rather than producing idiosyncrasy, experts in this area use some of the following criteria: (a) a brief interval of time elapses between exposure and the appearance of liver damage, (b) the severity of the toxicity produced is related to the size of the dose which is administered, (c) there is a high incidence of toxicity associated with administration of the drug to people as well as to experimental animals.

Hypersensitivity, on the other hand, is the type of toxicity to which most of the drugs which produce liver damage has been attributed. Some of the criteria which indicate that the damage is due more to hypersensitivity or idiosyncrasy than it is to direct or indirect toxicity are: (a) low incidence, (b) the toxicity does not usually appear on the first administration of the drug but requires a sensitization period of some weeks or days of exposure, (c) it recurs promptly upon the readministration of a small dose of drug, (d) the manifestations of hypersensitivity in the liver are often accompanied by other signs such as drug fever, rash, urticaria, and eosinophilia.

The drug-induced hepatic changes have been divided into parenchymal cell and

TABLE 2

Class of Drug	Hepatic Manifestation	Mechanism of Jaundice Production	Incidence
1. CENTRAL NERVOUS SYSTEM			
(a) **Tranquilizers** (1) Phenothiazine derivatives chlorpromazine (Thorazine) prochlorperazine (Compazine) mepazine (Pacatal) trifluoperazine (Stelazine) promazine (Sparine) (2) Non-phenothiazine chlordiazepoxide (Librium)	Hepatocanalicular jaundice with a lower incidence of parenchymal cell damage	Hypersensitivity mixed with indirect toxicity	1–5% Seen particularly on chronic administration
(b) **Monoamine Oxidase Inhibitors** (1) Hydrazine type *iproniazid (Marsilid) *pheniprazine (Catron) (2) Non-hydrazine type tranylcypromine (Parnate)	Parenchymal cell damage	Not readily classified since they do not show all the criteria for either direct toxicity or idiosyncrasy. **Possibly** an individual defect in hepatic enzyme profile.	About 1% and mortality is high, 15–20%
(c) **Anticonvulsants** (decreasing order of incidence) (1) phenacemide (Phenurone) (2) methyl phenylethylhydantoin (Mesantoin) diphenylhydantoin (Dilantin) trimethadione (Tridione) (3) phenobarbital	Parenchymal cell damage	Hypersensitivity	Of phenacemide, about 2% phenobarbital—very rare
2. ENDOCRINE			
(a) Antithyroid (thiourea derivatives) propylthiouracil methimazole (Tapazole)	propylthiouracil—parenchymal cell methimazole—hepatocanalicular	Hypersensitivity	Very low
(b) Oral hypoglycemics tolbutamide (Orinase) chlorpropamide (Diabinese)	hepatocanalicular	Chiefly hypersensitivity	Rare with tolbutamide. 0.5% with chlorpropamide
(c) Anabolic steroids methyltestosterone methandrostenolone (Dianabol) norethandrolone (Nilevar) fluoxymesterone (Halotestin) methenolone (Primobolan)	cholestatic jaundice	Proposed mechanism: competitive antagonism for secretory mechanism in bile canaliculi between anabolic steroid and one of normal bile acids such as cholic acid	High—readily reversible upon withdrawal of of drug
3. ANTIBIOTIC AND CHEMOTHERAPEUTIC AGENTS			
chlortetracycline (Aureomycin) erythromycin estolate (Ilosone) triacetyloleandomycin (TAO) chloramphenicol (Chloromycetin)	parenchymal cell	Indirect toxicity probably through competitive antagonism with normal host metabolites	For most of them low although triacetyloleandomycin may run to 4%
PAS (para-aminosalicylic acid)	mixed parenchymal cell and hepatocanalicular	Hypersensitivity	Less than 1% develop jaundice
INH (isonicotinyl hydrazide) Pyrazinamide	probably parenchymal cell	May be individual defect in hepatic enzyme profile—see iproniazid	Low for INH 3–5% Pyrazinamide
4. ANTINEOPLASTIC DRUGS			
chlorambucil (Leukeran) 6-mercaptopurine (Purinethol)	mixed parenchymal cell and hepatocanalicular	Indirect toxicity	High for 6-mercaptopurine, lower for others

*Withdrawn from market.

hepatocanalicular damage. The parenchymal cell type of damage produces jaundice which is similar to that of viral hepatitis, whereas the hepatocanalicular type of damage simulates extrahepatic obstructive jaundice. Thus drug-induced jaundice is considered to be associated with parenchymal cell damage if there is also present the histological change of hepatic necrosis. In hepatocanalicular jaundice on the other hand, there is usually no histological evidence of parenchymal cell damage but prominent bile stasis is seen on biopsy. The jaundice is often very deep and is associated with severe itching. It is felt that either toxicity or hypersensitivity can produce either parenchymal or hepatocanalicular damage.

In Table 2 the drugs which have been shown to produce hepatic damage have been classified on the basis of their pharmacological site of action. This runs the risk of having different types of hepatic manifestations seen among similar types of pharmacologically active agents but also serves the purpose of classifying drugs as to their site of action and acts as a warning as to what might be expected when this class of drugs is employed.

Listed below in Table 3 are some of the laboratory tests which may be of value in attempting to distinguish between the kinds of hepatic injury which might show up when drugs are administered to man.

Summary. (1) Many drugs now employed have an injurious effect upon the liver. (2) For the most part the incidence of injury is low. (3) For some drugs, although the incidence of injury may be low, the mortality of those affected is high, running in some instances (e.g., monoamine oxidase inhibitors), up to 20 per cent. (4) Many new drugs are currently reaching the market and as a result we may expect more and more hepatic toxicities. One further word of caution must be added. Most drugs which are employed are ultimately or primarily detoxified or disposed of by liver enzymes. Hepatotoxic drugs therefore may produce toxic blood levels not only of themselves but also of any other concurrently employed therapeutic agent.

TABLE 3—*Laboratory tests which may be of value to distinguish between parenchymal cell damage and hepatocanalicular damage*

	Parenchymal cell damage	Mixed parenchymal and hepatocanalicular	Hepatocanalicular
Urinary bilirubin	+	+	+
GOT*	4+	3+	+
BSP excretion impairment	4+	4+	4+
Plasma alkaline phosphatase	—	2+	4+

*Glutamic Oxaloacetic Transaminase.

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CLINICAL VALUE OF VENOGRAPHY OF THE LOWER EXTREMITY

HECKER, SYDNEY P., KRAMER, RICHARD A. and WEIGEN, JOHN F., Palo Alto Medical Clinic, Palo Alto, Calif.—*Annals of Internal Medicine,* 59: 798 (Dec) 1963.

Roentgenologic examination of veins following injection of a radiopaque substance was first accomplished in 1923, but later fell into disfavor because of various technical difficulties. The authors describe a recently developed technique in which 40 ml. of Hypaque are injected into a superficial vein on the dorsum of the foot. A tourniquet is placed on the ankle to occlude partially the superficial veins and thus promote deep vein filling. The patient is in semierect position, to delay venous emptying. Two cassettes with high speed screens permit exposures at completion of injection and 15, 30, and 60 seconds later. Postexercise films may make it possible to visualize more veins, poor emptying, and incompetent perforators.

Venography is of value in the diagnosis of acute thrombophlebitis and its differentiation from sciatica, trauma, muscular hemorrhage, cellulitis, and lymphedema. Venous thrombosis is diagnosed when there is persistent nonfilling of veins, or when persistent filling defects in otherwise well opacified veins appear on serial films. Venography may reveal previous thrombophlebitis and inadequate deep circulation in patients with superficial varices, thus contraindicating ligation and stripping. Unexplained leg swelling may be explained by demonstration of deep venous occlusion which has occurred silently. Serial venography helps to evaluate therapy by demonstrating thrombolysis and recanalization.

In 27 patients undergoing serial venograms to evaluate fibrinolytic therapy, some lysis occurred in 9. Serial venography is also valuable in evaluating surgical treatment and in studying the natural course of thrombophlebitis. Complications consist of pain, sometimes severe, at the injection site, and vasovagal syncope in a few patients.—Reprinted from *International Medical Digest,* May, 1964.

AMERICAN COLLEGE OF PHYSICIANS ISSUES FAMILY HEALTH BOOKLET

Advice on keeping families healthy is contained in a booklet published this month by the American College of Physicians (ACP). Titled "Your Physician Looks at Family Health," the publication features reports by experts in the fields of public health, adolescent medicine, alcoholism and nutrition. Material is based on presentations at a public information forum presented by the ACP in conjunction with its 45th Annual Session in Atlantic City, N. J. Single copies of the booklet can be obtained without charge from the American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Are All Physicians Assuming Their Responsibility in Cancer Detection?

By F. J. HOFMEISTER, M. D. and
DOROTHY M. BARBO, M. D.

Milwaukee, Wisconsin

The following abstracted material emphasizes the results of a survey made in Milwaukee County. The authors feel that this information could have great impact upon the practice of medicine in Wisconsin in stressing the fact that cancer detection needs to be more generally employed in the offices of physicians. The material has been abstracted from two articles: CANCER DETECTION IN PRIVATE PRACTICE OF GYNECOLOGY; CONCLUDING STUDY, *which has been accepted for publication in* Obstetrics & Gynecology, *Journal of The American College of Obstetricians and Gynecologists, and* OFFICE DETECTION OF GYNECOLOGIC MALIGNANCY—IS IT A REALITY?, *accepted for publication in* Postgraduate Medicine.

■ THE MAY 1963 *Wisconsin Medical Journal* reported to all physicians the tremendous advances made in cancer detection facilities and techniques available to Wisconsin physicians.

The authors have reported their experience in office cancer detection.[1] By a survey[2] of Milwaukee County physicians they attempted to determine what is being accomplished in other physicians' offices. A summary of their experiences in office cancer detection follows:

During a 13-year period when 18,972 Papanicolaou smears were made, 112 carcinomas of the cervix were treated. Of all cervical malignancies treated by one of the authors and his associates, 60.5% were detected and diagnosed by routine office procedures while asymptomatic and unsuspected.

The vaginal and cervical Papanicolaou smear was not rewarding as a method of detection of endometrial carcinoma. Only 23% of endometrial carcinomas treated *(all symptomatic)* had associated positive Papanicolaou smears. However, endometrial sampling by Randall and Novak curette methods were productive of detection. During a 13-year period when 8,962 such samplings were taken, 66 endometrial carcinomas were treated. Of all endometrial carcinomas treated during this period, 19.5% were detected and diagnosed while unsuspected and asymptomatic.

Finally, as far as could be determined, no instance of invasive carcinoma of the cervix or advanced carcinoma of the endometrium has developed in those patients who have submitted to yearly complete gynecologic examination which included routine Papanicolaou smears and endometrial samplings.

In the survey made of Milwaukee County physicians, 507 (42.6%) of a physician population of 1,190 responded. From those who responded, the following information was obtained:

1. Internists—79% (NOT 100%) did routine Papanicolaou smears. Of these 50% were limited to women over the age of 35.
2. General Surgeons—70% (NOT 100%) did routine smears. Of these 50% were limited to women over the age of 35.
3. Obstetricians and Gynecologists—95% (NOT 100%) indicated that they did routine Papanicolaou smears. Of these 54% did Papanicolaou smears on obstetric patients, and 60% did routine smears only on women above the age of 35.

   It should be noted that 100% of obstetricians and gynecologists DID NOT routinely do Papanicolaou smears.
4. General Practitioners, Family Physicians—64% (NOT 100%) indicated that they did routine Papanicolaou smears. Of these 55% limited this procedure to women over the age of 35, and only 18% did routine Papanicolaou smears on pregnant women. THIS IS A GREAT HAZARD SINCE THE GENERAL PRACTITIONERS DELIVER 70% OF THE INFANTS IN WISCONSIN.

Endometrial Sampling. As expected, the use of routine endometrial sampling does not enjoy the popularity of the Papanicolaou smear.

1. Surgeons—5% did routine endometrial evaluation; 58% (NOT 100%) advised curettage for abnormal bleeding; 54%

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(NOT 100%) for postmenopausal bleeding.

2. Obstetricians and Gynecologists—58% indicated the use of routine endometrial biopsies; 92% (NOT 100%) do endometrial evaluation by hospital dilatation and curettage when postmenopausal bleeding occurs.
3. General Practitioners, Family Physicians—13% do routine endometrial evaluation; 68% (NOT 100%) advised hospital curettage when hazardous postmenopausal bleeding existed.

It was shocking that the time-proven and taught methods of hospital curettage when telltale symptoms of postmenopausal bleeding exist have NOT been accepted and used by 100% of physicians in any category of practice. It was surprising that the much publicized, frequently requested, and many times proven efficient Papanicolaou smear has NOT been reported as being used 100% by any group of physicians, including the obstetrician and gynecologist.

It was even more surprising and shocking to note that physicians apparently imagine a protective halo around women up to the age of 35, since many physicians seem to prefer the use of cancer detection facilities only on women above the age of 35. The youngest patient with invasive carcinoma of the cervix treated by the senior author and his associates was 19 years old. The youngest patient with endometrial carcinoma treated by them was 38.

It is significant to realize that unless concerted efforts are made by each and every physician to dedicate his office as a cancer detection center, the work will go on haphazardly; whereas, if this dedication is realized, gynecologic malignancy could ultimately disappear. Cancer detection must be a 100% effort. Youth or age affords no protection.

"Heroic surgery is now, relatively speaking, commonplace. But the results should make us realize that more important than the brilliant technical advances in surgery are the less spectacular advances in early diagnosis and treatment. The unfortunate women who must undergo exenteration are mute witnesses to the fact that somewhere along the line there was a failure in the detection of early carcinoma."[3]

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"TRANQUILIZING" DRUGS

"Tranquilizing" drugs are misnamed and show broader effects than previously suspected, according to a recent report by scientists at the National Institute of Mental Health, Public Health Service, U.S. Department of Health, Education, and Welfare.

New evidence indicates that the phenothiazines, the most widely used of the "tranquilizers," improve the passive, withdrawn, apathetic patient even more than the agitated, abusive one. The drugs' action, therefore, is broader and more versatile than is presently outlined in standard medical texts.

This finding was reported by Dr. Jonathan C. Cole, Director of the Institute's Psychopharmacology Service Center, at a Veterans Administration Psychiatric Conference held recently in Kansas City, Mo.

His conclusion was based on a nine-hospital collaborative study of 340 patients, financed and directed by the Service Center. It showed that the following symptoms which are considered fundamental to schizophrenia are the most improved by the phenothiazines: poor social participation, poor self-care, confusion, indifference to environment, and hebephrenic gestures.

Psychiatric teams which evaluated patients with these symptoms after six weeks of drug therapy found them markedly improved. "In contrast," Doctor Cole added, "hostility, agitation, anxiety, and ideas of persecution—symptoms which are usually regarded as 'target symptoms' for tranquilizing therapy—although influenced by the drug treatment, were not affected to as great a degree."

"During the past dozen years," he said, "the phenothiazines have been stereotyped as 'ataractics' or 'tranquilizers,' the implication being that their dominant action is to calm excited patients by relieving the patient's anxiety. . . We have presented evidence to confirm that phenothiazines . . . have a wide variety of clinical effects beyond tranquilization."

The drugs were shown to act in two ways, according to the study's coordinator, Dr. Solomon Goldberg. They alleviated the patient's pretreatment symptoms, and prevented the development of other schizophrenic symptoms the patient did not have before treatment. The authors conclude that the drugs seem to have a general alleviating and preventive antischizophrenic action, and can be used appropriately for a wide variety of schizophrenic patients.

A GUIDE: Principles for Transporting the Ill and Injured

Prepared by the Division on Safe Transportation of the State Medical Society, and approved by the Commission on State Departments March 8, 1964, and by the Council May 10, 1964.

It is the concern of the medical profession that the ill and injured receive proper first aid and safe transportation to a location where medical treatment is rendered.

Organization of emergency transportation services will vary in different communities, since the capabilities of the communities to provide them will differ. Realistic goals in the less densely populated areas will differ from those in cities. In cities it may be desirable to establish safe transportation regulations for transporting the ill and injured by local ordinance. Such model ordinances to be adapted to local conditions are listed as references 1 and 2.

Aims for emergency transportation services are:

1. Safe transportation of the ill and injured to medical facilities.
2. Manning of emergency vehicles for transporting the ill or injured with personnel—where feasible, both a driver and attendant—who can give emergency first aid according to the standards of the American Red Cross and/or the local county medical society.
3. Availability of proper vehicles with equipment for dressing wounds, splinting fractures, controlling hemorrhage, maintaining the airway and providing oxygen.

It is to assist in the organization and improvement of local services for transporting the ill and injured that this guide is developed. Its recommendations are considered applicable to both privately and publicly operated ambulances and dual-purpose patrol cars.

Qualifications and Training of Drivers and Attendants

It is recommended that personnel involved in the transportation of the ill and injured meet the following standards:

1. Ambulance drivers should be 21 years of age or over and attendants 18 years of age or over.
2. Personnel should be in good general health. The following examination standards are suggested:
   a. A minimum best correctable visual acuity of 20/40 in each eye.
   b. A minimum horizontal form field of 70 degrees in each eye.
   c. Color perception should be tested and when weakness is present the applicant should be informed and cautioned in this regard.
   d. Functional use of both hands and of the foot normally employed to operate the foot brake and foot accelerator.
   e. No history of fainting attacks, epilepsy, narcotic or alcoholic addiction.
   f. Serviceable and practical unaided hearing ability. (It is preferred that a test be made wherever possible on a pure tone audiometer. The results should show the average hearing loss in the better ear in the three speech frequencies (500 cps, 1000 cps, 2000 cps) to be no greater than 30 db. unaided.)
3. Proficiency in operating a motor vehicle and maintenance of a good driving record.
4. Ability to speak, read and write the English language.
5. Possession of a valid certificate of completion of the advanced course in first aid training from the American Red Cross, or its equivalent, including training in emergency obstetrics and oxygen therapy as approved by the county medical society.
6. Submission of adequate character reference.

Equipment and Maintenance of Emergency Vehicles

The following equipment is recommended for vehicles used in transporting the sick and injured:

Airways, both adult and pediatrics sizes (SAFAR airway or similar device).

Inhalator with oxygen tank of 1,500 pound capacity, with face mask and gauges approved by county medical society.

One extra set of clean linen.

One crash pouch.

Two leg splints, one hip length and one knee length, basket type.

One leg splint, equipped for traction.

One arm splint, basket type.

Two pillows for emergency splinting not amenable to standard splints.

Q-Tips.

Gauze squares (4 inch, 1 dozen).

Abdominal pads (4).

Massive compression dressing.

Scissors.

Band aids and adhesive tape.

Tourniquets.

Triangle bandages (5).

Roller bandages (2 inch, 6 rolls).

It is also recommended that ambulances be equipped with recessed overhead attachments for holding intravenous fluids being administered.

Maintenance

The following recommendations are made for maintenance of vehicles used in transporting the ill or injured:

1. Parking in a heated garage during the winter months when not in service. Adequate off-street parking facilities for other seasons.
2. Decontamination after transporting persons suffering from contagious diseases.
3. Maintenance in a clean and sanitary condition and availability for inspection by local health authorities at any reasonable time.
4. Full time availability.
5. Seat belts for both driver and attendant and companion riding with the patient. Provision should be made for securing the patient in the vehicle.
6. Daily inspection of condition of tires, battery, brakes and lights and supply of gasoline, oil and water.

Conduct of Emergency Vehicles in Traffic

While transporting the ill or injured, it is recommended that emergency vehicles:

1. Observe all traffic and speed laws in the zones traveled.
2. Have the right-of-way over other traffic when enroute to the scene of an emergency or when returning with a patient.
3. Be equipped with a siren and flashing red light to be used in accordance with state law or community ordinance.

Conclusion

It is through the cooperative efforts of the medical profession, operators of emergency vehicles, local officials and interested citizens that establishment of services for safe transportation of the ill and injured and improvement of existing services can be accomplished.

REFERENCES

1. "A Model Ordinance or Statute Regulating Ambulance Service," prepared by a Joint Committee of the American College of Surgeons, the American Association for the Surgery of Trauma, and the National Safety Council.*
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3. City of Des Moines, Iowa, Ordinance.
4. City of Flint, Michigan, Ordinance No. 435.
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6. Curry, G. J. and Lyttle, S. N.: "The Speeding Ambulance," Journal of the Michigan State Medical Society, 56:1140, September, 1957.
7. Hampton, O. P., Jr.: "Transportation of the Injured, A Report," Bulletin of the American College of Surgeons, volume 45, page 55, January–February, 1960.

* Copies available on request from the State Medical Society of Wisconsin for use as model ordinances for states and communities.

Note: The community ordinance, reference 2, as written, applies only to privately owned and operated ambulances. Both model ordinances should exempt doctors of medicine and registered nurses from specific training requirements.

DIVISION ON SAFE TRANSPORTATION

The following physicians served as members of the Division on Safe Transportation of the Commission on State Departments during the period in which the "Principles for Transporting the Ill and Injured" were developed.

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* Deceased.

The State of Wisconsin

WISCONSIN RETIREMENT FUND

459 WEST GILMAN STREET

MADISON 53703

WISCONSIN PHYSICIANS COOPERATE IN OPERATION OF STATE DISABILITY ANNUITY PROGRAM

The Wisconsin Retirement Fund, which covers approximately 55,000 state, county, municipal and school district employes, has just completed 20 years of administering a program of disability annuities for participating employes who became totally and permanently disabled.

This retirement system has used a procedure which is substantially more informal than that used by Social Security or by systems in other states also granting disability annuities. Yet this simple plan has been very effective due primarily to the very fine cooperation received from Wisconsin physicians.

Under the law at least two licensed and practicing physicians designated by the board must certify that the applicant is considered totally and likely to be permanently disabled, not only for the former position but also for the duties of any position. Ordinarily the certificate of the attending physician is acceptable, plus that of a medical examiner designated by the system.

Very frankly those administering this provision were initially fearful that this plan might not provide adequate safeguards. In practice the problems have been few. This is primarily because Wisconsin physicians have been conscientious in evaluating the condition of each applicant.

Unlike many other plans the retirement system relies primarily upon the conclusions of the examining physicians, believing that they are the best qualified to know what the facts are.

One problem has been that some physicians do not meet the request that in their report they should avoid technical terms as far as possible and should emphasize the completeness and probable duration of the disability. The board of trustees has the ultimate responsibility for approving disability annuity applications, and no board member has any technical medical knowledge.

Another problem has been that where special conditions are involved, the physician with the most experience in that particular field may conclude that he does not have the time to act as the medical examiner upon behalf of the retirement system.

Because of the careful cooperation of Wisconsin physicians the retirement system has in practice been able to limit the granting of disability annuities to those who really qualify. In some states such a plan has been administered rather loosely. The director of the retirement system personally visits each disability annuitant annually, and while he is thoroughly aware of his own limitations in making judgments, most cases are so obvious that there is virtually no doubt as to their continued qualification. In doubtful cases a re-examination by a physician is required.

Since it has been possible to limit approvals to those who really qualify, the result has been that over the years the disability annuity benefits have been steadily liberalized by the legislature until now such are substantially more generous than those which prevail generally in other retirement systems.

The system actuary reports that although the disability annuities are liberal, the mortality experience among disability annuitants is about four or five times as great as for annuitants generally. The result is that the actual cost has not been excessive.

Frederick N. MacMillin
Executive Director

EDITOR'S NOTE: The determination of disability for purposes of benefits under the Wisconsin Retirement Fund is wholly unrelated to disability determinations for benefits under the Social Security program. The latter is handled in Wisconsin through the State Board of Vocational and Adult Education's Division for Vocational Rehabilitation.

THE PRESIDENT'S PAGE . . .

W. P. CURRAN, M.D.
Antigo, Wisconsin

Comments on AMA Meeting

■ THE RECENT MEETING of the American Medical Association in San Francisco was very well attended by the physicians from the 50 states of the United States and was satisfying to all who were there, both on a scientific and legislative basis. The scientific lectures did not want for attendance and the scientific exhibits were of a high caliber. They were very well received by the many thousands who added pain and discomfort to their respective metatarsal arches during the walk through the Civic Auditorium.

The proceedings of the House of Delegates were of great interest to all who attended, either as a delegate or as an observing member of the AMA. It is amazing to see the amount of material that is acted upon during these sessions and how well the meetings are conducted by the able Speaker of the House, Dr. Milford O. Rouse, of Dallas. Of special interest were the meetings of the various committees on Tuesday, June 23. It is at these meetings that one can see and hear the thinking of the various men from varied localities as they discuss the problems before the House. And great credit is due the men who take their time to appear before these various committees to express their views, whether right, wrong, popular, or unpopular. Some of these committees are chaired by delegates from Wisconsin. I was proud to see the good job they are doing.

During the morning session of the House, on June 24, a news release referring to the fate of the King–Anderson legislation in the Rules Committee of Congress was read, and a jubilant response by the members of the House was heard. Following this announcement the Speaker recognized Dr. D. G. Hall, who is a physician member of Congress. He was pleased with the news, but admonished all those present that this press release did not mean that there could be any relaxation on the part of organized medicine in controversy now going on in connection with this type of legislation. He emphasized the continued importance of "Operation Hometown" as well as continued letters to our elected representatives in Congress. He also stressed the importance of talking to the people, giving them the information they need to better understand medicine's viewpoint and to show them what really will happen if, because of our relaxation, such legislation should come to pass.

I hope that all physicians who have been doing their job in such matters will continue their efforts, and to those who as yet have not joined the team: "welcome aboard." The expression of Doctor Rouse: "The price of liberty is eternal vigilance and also diligence," is very apropos.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

AUGUST 1964

Vol. 63 No. 8

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Children in Jeopardy

THE INCREASINGLY frequent presentation of grossly abused children offers a thorny ethical problem to doctors. When a physician is asked to treat a child for injuries that appear to have been inflicted by an older person, and when the parent insists that the child incurred them accidentally, should the doctor respect the confidence of his patient, or should he take thought for the welfare of the child by reporting to the police what he believes to be a case of assault?

Hard as it is for most people in our child-oriented society to believe, hundreds of children are beaten, burned, cut, whipped and deliberately starved in our country each year. A study by the American Humane Society found 662 cases of abused children reported in the newspapers in 1962—yet most cases are never reported. Of the 662 reported cases, the injuries to over 165 of the children proved fatal. The number of children who go through life with warped personalities and severe emotional disturbances because of physical violence suffered in their childhood must be legion. Like a curse in a Greek tragedy, these memories of rage-filled beatings become repeated patterns of behavior from generation to generation, creating ever more violent reactions to life's frustrations.

What can the doctor do? Is he compelled by his code of ethics to accept the parents' transparent cover story except in the most flagrant cases? Must he be indifferent to, and therefore condone, gross forms of neglect, abuse and mistreatment applied to children for the sake of his commitment to respect his patient's confidence? Or should he meddle in the intimate relationship existing between parent and child, violating the most fundamental right of privacy and individual sanctity? Is the doctor justified in intervening only when a child is brought to him broken and bleeding? Or should he take action when he first notices a core of rage in a parent's handling of his child? If he wants to take early action, what is he going to do about it?

Unfortunately, there is not too much a doctor can do at the present time in most states. Certainly the doctor must

In 1963 the Wisconsin Legislature enacted a law which permits the physician or surgeon to report reasonably suspicious cases to a law enforcement official.

be aware of the problem and face up to the fact that parents can be guilty of willful abuse of their children. He must invariably report flagrant cases of assault to the police for whatever action the laws on the books provide. Beyond that, anything he does at the present time must be in the realm of whatever private measures he can effect to prevent recurrences of bizarre punishment to the child.

The medical profession, however, can do something. It has a moral obligation to bring the matter before the community and require laws that will enable the individual doctor to bring techniques of social service and psychiatric care to the problem. Laws for punishing a parent for mistreating the child are not the answer, for such punishment must follow damage to the child and can only be applied in flagrant cases. What is required is legislation that will establish agencies for handling disturbed parents before their rage manifests itself as violence on the bodies of their children. There must be a system of reporting child abuse with provision for evaluating and investigating reports. There must be sources of assistance set up to offer help to both parents and children.

If the community is interested in protecting the persons of its children from disease, it must certainly concern itself with the jeopardy in which children find themselves from their parents. If the community cares enough about the welfare of its children to provide an educational plant worth billions of dollars, it must reasonably be concerned with the mental health and emotional stability of these same children. We must recognize the need for community interference into a relationship that up until recently has been about as private as a relationship could be—that existing between parent and child—when that relationship is so perverted that the welfare of the community is affected.

The problem and the solutions must be publicized; the community must be made aware of what damage is being done to it by its brutal parents and their scarred children. The shocking, scandalous facts must be publicized for the sake of the social health of the community. The medical profession, which first sees the victims of parental violence, must start the job.

Abuse of children is one problem to which doctors are privy. If we let it continue to grow without constructive action to prevent it—both as individual doctors and as a profession—we are sadly remiss in a moral responsibility even higher than our respect for privileged communication. —D. N. G.

Priceless Ingredient

THE COMPLEXITIES of modern medical practice make it impossible for the doctor to talk to every patient who calls for an appointment. He must rely on his medical secretary to schedule his visits and to keep his flow of work in an orderly and systematic manner. He must also rely on his medical secretary to reconcile the realities of his schedule with the requirements—real or imagined—of his patients. And here is the rub.

The ideal medical secretary presents the doctor's kindly face to his patients at the first contact. She firmly and methodically schedules his day, giving first priority to those urgently in need of medical care. She must be tactful, considerate, sympathetic, kind and stable; yet she must have an instinctive feeling for the true emergency.

Where are such paragons found? Perhaps some are born, and lucky is the doctor who has one to intercede between him and his patients. Most, however, are trained over a long period of time with careful supervision and painstaking thoroughness. The training is worth the doctor's effort, for his reputation in the community can be damaged by an inept or tactless secretary.

It behooves every physician to supervise his medical secretary closely to avoid mistakes that might be harmful to his patients. A doctor is entitled to free time to do his paper work and to enjoy a moment of leisure, but his patients are entitled to a doctor's immediate attention in an emergency and a sympathetic handling of their problems. The medical secretary must be made sensitive to the feelings of the patients as well as the requirements of her employer's work program.

County, State and National Medical Assistants Societies deserve all of the support that can be mustered by individual physicians and their medical organizations—all have the same goal. —D. N. G.

VACCINES WHIP POLIO—No Longer a Dread Season

WITH THE APPROACH of what once was the dread polio season, Madison and Dane county owe a vote of thanks to the Dane County Medical society in particular and medical science in general.

The disease which once was feared by every parent has been all but whipped. The SOS (for Sabin on Sunday) clinics of the Dane County Medical society are giving a final coup de grace.

There was not a reported case of polio in Dane county in 1962 and 1963, thanks in great part to the widespread use of the Salk vaccine. In 1959, 1960 and 1961 there was only one case each year. In 1958 there was none.

These were the post-Salk vaccine years. Now for the record of the years before the Salk vaccine.

In 1957 there were 15 reported instances of polio in Dane county, with one death. In 1956, there were 14 cases and two deaths. In 1955 there were 281 cases and 16 deaths. In 1954 there were 44 cases, with one death, and in 1953 it was 44 cases and no deaths. In 1952 there were 202 cases and 13 deaths.

The Sabin vaccine administered last winter and spring by the Dane County Medical society gave the community the advantage of having a protection that does not need booster shots and one which eliminates carriers among those who show no evidence of the disease.

The program was so well carried off that an estimated 90 per cent of the population was given the Sabin protection. There has been another benefit.

The cost of the vaccine was at rock bottom due to the tremendous number of doses purchased. The cost of administration was nil, due to the use of city schools for space and volunteer help. Even at the low price of 25 cents for each of the first two doses, it was apparent that a "profit" would be made.

The third dose was given at no cost, and the $29,000 "profit" was turned over to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin to be used as a revolving fund in the education of needy Dane county students interested in medicine, dentistry, pharmacy and nursing.

The program was one of great benefit to Dane county. The medical society and the hundreds of volunteers who aided in the effort are to be congratulated.—Reprinted from the *Wisconsin State Journal*, June 11, 1964.

HEALTH INSURANCE TRENDS

The first edition of a periodical for the medical profession, "Health Insurance Trends," was published in June by the Health Insurance Council.

Designed as a report to physicians of progress made by the nation's insurance companies in the financing of health care, the report will be issued bi-monthly by the Council.

It will review problems of mutual concern to the medical profession and the health insurance business, with emphasis on areas of joint cooperation. Among the topics to be covered by the new report will be the function and goals of medical society review committees and other programs to conserve the public's health care dollar, as well as simplified claim forms and similar matters of interest to the physician.

"Health Insurance Trends" is being distributed to more than 7,000 physicians, including delegates and alternates to the American Medical Association's House of Delegates, state and county medical society presidents, public relations chairmen and executive secretaries and editors of state and county journals.

The Health Insurance Council, as spokesman for the health insurance business to the providers of health care, is a federation of associations representing insurance companies which issue more than 90 per cent of the health care coverages written by insurance companies.

OCCUPATIONAL HEALTH TREATISE

What every physician who provides medical services for an employee group should know is the subject of a comprehensive guide just published by the Occupational Health Institute, the educational arm of the Industrial Medical Association. The 80-page treatise entitled "Organization and Operation of an Occupational Health Program" was prepared for the OHI by Dr. J. S. Felton, professor of occupational health, University of California, Los Angeles.

Requests for copies may be sent, with 40 cents in postage to cover mailing and handling, to the Occupational Health Institute, 55 East Washington Street, Chicago, Ill. 60602.

BRAND NAMES FOR PLACEBOS?

Clinicians are experiencing serious difficulties in conducting double-blind studies which, ironically, are all the more necessary because of the new (FDA) regulations. As one company vice president put it, placebo preparations cannot be sent out without being so labeled; when so labeled, they cease to be placebos. In fact, the need to file an investigational drug form just to change an approved tablet into a capsule for the purpose of such studies unnecessarily delays or prevents such testing.—AUSTIN SMITH, M.D., President, Pharmaceutical Manufacturers Association, to Federal Bar Association meeting, Washington, D. C., June 27, 1963.

the wisconsin medical journal

VOLUME 63/NUMBER 9 SEPTEMBER 1964

Dermatological Disorders in Athletes

By DONALD M. RUCH, M.D.
Milwaukee, Wisconsin

■ DERMATOLOGISTS FEEL that dermatological disorders in athletes receive inadequate attention from all parties concerned: the athlete himself, the coach, the trainer, and often the physician. This indifference is usually more evident at the high school than at the college or professional levels, because there is usually no physician present at the high school sports activity unless the event is a scheduled conference game. This report briefly calls attention to the skin lesions most frequently seen in sports participants and stresses the importance of preventive measures in the approach to them.

Athletes are, of course, subject to all the skin disorders usually seen in youths of their age, but they are also more susceptible to certain other lesions than are nonathletes. The fact that they usually have fine muscle tone and excellent coordination, and are in a state of radiant health, promotes an attitude of indifference to slight skin eruptions. They can't be bothered. And so the disorder becomes progressively worse as the competitions pile up through the season.

The skin diseases presented are not in the strict order of their frequency.

Contact Dermatitis. This eruption is caused by agents that are touched, worn, or applied. Frequent sensitizers are tincture of benzoin, mercury compounds (Merthiolate, Metaphen, Mercurochrome), liniments, dyes, leather, rubber, adhesive tape, plastic materials, lime, and chalk. We have seen several patients with disabling dermatitis from elastic knee supports and adhesive tape, and also instances of slightly less severity in which swimming trunks and baseball gloves were involved. Wrestlers may acquire a contact type of dermatitis from the use of muscle-toning ointments, which frequently contain 'caine derivatives or such sensitizing agents as Campho-Phenique.

Successful treatment of this disorder requires early detection of the skin irritation and prompt recognition and elimination of the sensitizing agent. Local wet dressings and steroid lotions and creams are beneficial.

Verrucae. These wart lesions disable by reason of both location and size. Pressure point pain may be quite severe, particularly on metatarsal areas. Basketball players who must run continually are particularly handicapped by these lesions, and verrucae can be serious matters when they involve the palms

Fig. 1—Contact dermatitis of the feet in a boxer due to sensitivity to Campho-Phenique, used as a liniment.

Fig. 2—Tinea infection of the face and neck in a wrestler.

Fig. 3—Pyoderma of the scalp, face, ears, and neck in a wrestler.

or palmar surfaces of fingers in a baseball player. The preferred therapy is electrodesiccation or use of liquid nitrogen.

Molluscum Contagiosum. This viral lesion may appear any place on the body, but is most common on the trunk. It is transmitted by contaminated towels and mats or through personal contact, and is most often seen in wrestlers. The best form of treatment is incision and evacuation of the molluscum body with application of 5% silver nitrate to the area, or treatment with liquid nitrogen.

Dermatophytosis. One of the most frequently encountered areas of indifference among athletes, coaches, trainers, and team physicians relates to both bacterial and fungous infections. The lesion most often misdiagnosed and improperly handled is trichophytosis; but frequently a contact dermatitis is called a fungous infection, and a pyoderma or bacterial infection is treated as a dermatophytosis. Bacterial infections and contact dermatitis may, in fact, often resemble a trichophytosis, especially if the feet and buttocks are involved. The most common types of dermatophytosis, in the relative order of the frequency with which we see them, are tinea cruris, tinea pedis, and tinea of the buttocks and trunk.

It is very important to diagnose and institute treatment early in these cases, especially if the feet or groins are involved. On the feet the lesions may be of the acute vesicular type, with tiny pinhead size vesicles on the soles or on the sides of the toes and in the webs of the feet, with redness and swelling at the base of the lesion. The eruption is usually unilateral from the beginning, and if it has been present for some weeks there may be some clearing at the center with activity at the margins.

A chronic type of dermatophytosis of the feet is also seen, with maceration and scaling of the toes and webs and in patches on the feet. To differentiate this fungous infection from a contact dermatitis, one should remember that in the latter there is symmetrical involvement on both feet, with redness and swelling and a sharp margination, especially if the sensitization is due to the leather, glue, or dye in the shoes. In the case of a pyoderma there is usually pustulation present, but some of these lesions may be vesiculopustular in nature.

Prevention is of utmost importance in this malady. Athletes should be advised to wear shower clogs, cover the dressing bench or chair with a towel, and dust the feet frequently with a fungicidal powder. Foot baths are worthless. Athletes with tinea cruris, in which the lesion is often fan-shaped, should wear boxer shorts under the jockey strap.

In treatment, wet dressings and foot soaks with potassium permanganate or copper sul-

fate are beneficial. In the acute phase, a 2% sulfur/calamine emulsion is advisable; in the less acute stage, application of sulfur and undecylenic acid cream is often very helpful. Griseofulvin, the oral antifungal antibiotic, is effectively used in the more severe cases.

Pyoderma. The athlete's scratching and irritating an underlying pruritic dermatitis may invite severe local infection with Staphylococcus or Streptococcus. This occurs most often in wrestlers and is the most potentially dangerous of all skin infection. The patient should be denied both practice and competition until complete healing has occurred; this is mandatory not only for his own sake but also because he may otherwise transmit the infection to teammates and competitors. These pyodermas may be superimposed on a fungous infection, and sometimes an underlying parasitic infection, as with scabies, may be masked by multiple small boils scattered over the trunk and in the axillae or groins.

If the athlete has a boil, it is especially important that the physician not allow himself to be persuaded to incise it before it is fluctuant so that a competitive game may be entered. Cellulitis and a deep pyoderma may ensue in such instances. If furunculosis does not respond to appropriate treatment, cultures and sensitivity tests become necessary.

Vincent's Disease. This acute edematous and vesicular inflammation of the mouth, caused by the fusiform bacillus and Spirillum vincentii, is easily transmitted by contaminated water cups and water towels that are used in common. The acute gingivostomatitis and acute gingivitis of this malady may be a seriously handicapping affair to the athlete. Treatment comprises the use of antibiotic lozenges and germicidal mouthwashes and systemic antibiotic therapy in severe cases.

Moniliasis. Candida albicans causes a moderately severe dermatitis, especially in the groins and axillae; stomatitis may also develop. Like Vincent's disease, this infection may be transmitted by the common use of drinking cups and sucking towels. Nystatin suspension as mouth wash, and nystatin lotion and ointment for the glabrous skin, are helpful.

Acne vulgaris. Preexisting acne may be tremendously aggravated by the football helmet (secondary pyoderma may result) and by

Fig. 4—Gingivastomatitis in a basketball player, a manifestation of Vincent's disease.

irritation of shoulder pads, body and mat contact. Appropriate therapy is the institution of local and skin hygiene and cleansing of the helmet with benzalkonium chloride (Zephiran chloride). In severe cases systemic antibiotics should be used.

Miliaria rubra. This condition is seen most frequently in basketball players and runners who sweat a great deal. Treatment consists of frequent showering and use of a zinc and starch dusting powder.

Prevention is a highly important element in the handling of skin disorders in the athlete. Since some individuals are much more prone to the development of infections of all sorts than others, it is imperatively necessary that the athlete be forbidden to walk barefooted in the shower or locker room. Proper attention to foot care is important also. Every individual should inspect his feet carefully daily to look for "hot spots" on the soles or sides; i.e., red, hot, and tender areas that are the forerunners of blisters from the trauma of improperly-fitting shoes. Since tincture of benzoin makes the skin sticky, it should not be used on the feet; a grease or powder or silicone, which will allow material to slide over the feet, is preferable. First aid should be sought immediately if a blister forms: withdraw the fluid with a sterile needle and syringe and cover the area with an antibiotic. A commendable practice in some athletic departments is to require players to alternate daily between two pairs of shoes so that the pair worn in the competitive game has already been worn several times during the week.

Fig. 5—Clean athletic equipment as issued for each practice and game by a Wisconsin high school athletic department.

Fig. 6—Dirty athletic equipment as used daily for three weeks by a Wisconsin high school athlete.

Most important of all in prevention is cleanliness—clean bodies and clean equipment. Showers should be taken frequently and thoroughly. Clean socks, towel, and jockey strap should be used for each practice and game. Use of the individual water ejector type of squeeze-bottle is important in preventing moniliasis and Vincent's disease. Frequent use of foot powder, abolition of foot baths, and more careful inspection of the skin will help in the prevention of dermatitis.

All athletes should be firmly instructed to report any skin disorder whatsoever at once so that prompt attention may forestall extension or complications. Any dermatitis of more than minor degree should be seen at once by the team or family physician.

740 Marine Plaza (53202).

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THE HYPERGLYCEMIC EFFECT OF HYPOTENSIVE DRUGS

Okun, Ronald, Wilson, William R. and Gelfand, Martin D.: *Journal of Chronic Diseases* 17:31 (Jan.) 1964.

In an investigation of the hypotensive properties of diazoxide, given orally and by intra-atrial injection, several patients developed hyperglycemia. A survey of the literature gave no clear or consistent picture of the incidence or mechanism of this change following the injection of hypotensive drugs.

Seven hypertensive patients received single intravenous infusions of diazoxide, hydralazine, guanethidine, hydrochlorothiazide and isotonic saline solution at weekly intervals in a random sequence. Arterial blood pressure, pulse rate and blood sugar were measured before, and at intervals up to three hours after, each infusion.

In the doses used, diazoxide appeared to be the most potent hypotensive drug. Coincident with its hypotensive action it quickly raised the blood sugar. Hydralazine and guanethidine had only a slight and delayed effect in raising the blood sugar, but both drugs lowered the blood pressure. Hydrochlorothiazide had no significant effect on either. The hyperglycemia produced by acute intravenous infusion of the hypotensive drugs studied is not easily explained by reflex responses to hypotension or by catecholamine release.—Reprinted from *International Medical Digest*, April 1964.

CARDIAC SERVICES DIRECTORY

A Cardiac Services Directory listing most of the state's hospitals and institutions at which heart patients can receive aid is now available to Wisconsin physicians. Published by Wisconsin Heart Association's Milwaukee county unit, the new guide has already been distributed to every Wisconsin hospital. It contains a complete informational record of services, fees, locations, and hours. Copies of the Directory can be obtained from the Wisconsin Heart Association, 205 W. Highland ave., Milwaukee. A $1.00 fee is asked to cover production and handling costs.

Iliac Passion: A History of Appendicitis

By JOSEPH C. KISER, M. D., Madison, Wisconsin

■ THE STORY OF appendicitis belongs almost exclusively to the nineteenth century. Prior to that time some autopsy records list abnormalities of size, shape, or position of the appendix which were regarded merely as curiosities. Lesions of the appendix were looked upon as secondary to the disease of other parts of the intestine. A study of the ancient mummies indicated that people had appendicitis but there is no evidence that their contemporaries knew what ailed them. Celsus, the Roman physician and medical historian of the first century, gave an account of the gross pathologic changes which have been described as appendicitis, but their significance was not appreciated.

In the first half of the sixteenth century, Jean Fernel described for the first time what may have been a case af acute appendicitis which became perforated and caused peritonitis. However, the anatomical terms were uncertain and the validity of this report is questionable. In 1736, Claudius Amyand (London) described a case of fecal fistula with a hernia in an 11-year-old boy. In 1759, Mestivier's classical case of the first recorded disease of the appendix appeared. The time-honored treatment of abscesses of the right lower quadrant by incision and drainage was carried out and a perforated appendix was found in the middle of the abscess.

Lamotte, Parkinson, Villermet, Melier. In 1766 the first account appears in the literature of fecal concretions in the vermiform appendix. Joubert Lamotte presented a postmortem report in a case of death from intestinal obstruction. The cecum was found filled with whole cherries and a hard body the size of an orange, slightly elongated and weighing 4 oz., was found contained in a wider than normal appendix. Up until 1808 the history of vermiform appendix consisted of four cases distributed over a 50-year period.

In 1812, one of John Hunter's famous pupils, John Parkinson (London), reported a case of a 5-year-old boy in whom a perforated appendix was recognized as the cause of death, and Parkinson is therefore entitled to credit of priority in this respect.

In 1838, Wegler, a German, described a postmortem case of an 18-year-old boy in whom the cecum was found to be gangrenous, the gangrene having its starting point in the appendix. It was described as containing four stones, three the size of a pea and the fourth the size of a pigeon egg. He regarded these stones as biliary calculi and this is the first of a series of statements occurring in this early period where biliary calculi were reportedly found in the appendix. None of these claims was ever substantiated.

In 1824, Villermet (French) established a definite place for lesions of the appendix in the category of recognized diseases. He was first to recognize that the appendix as a diseased organ could have an individual history. He presented two autopsy cases and described "coldness of the dorsum of the right foot" as an interesting prodrome of the disease. Remedies such as poultices and leeches to the right iliac fossa were used in his patients without effect and they grew gradually worse until they finally died on about the fourth day "tranquilly." "Placida morte" is frequently alluded to in the early description of appendicitis.

In 1827, Melier (French) published an article so full of thought and insight that it may well have marked a historical epoch in the subject had the author possessed the courage of his convictions and had he been able to combat Dupuytren, the greatest surgical authority of his time. In Melier's opinion, the fecal matter accumulated in the appendix, which then dilated little by little, becoming first inflamed and then gangrenous and finally perforated. Melier's article may be considered as the first stage in the evolution of the knowledge concerning the vermiform appendix in that he established the

possibility of primary disease in the appendix. The further development of the subject was slow and uncertain owing to the great misdirection of effort. The history of appendicitis affords at this point, a striking example of the difficulties encountered by originality of idea when opposed by the weight of established authority.

In 1833, Dupuytren formally expressed his opinion, although he no doubt had long before orally impressed it upon his students. He stated emphatically that right iliac fossa abscesses occurred in the right side rather than the left because the intestinal tract ceases at this point to be freely movable, that food material here becomes excremental in character and has to be forced upward in opposition to the law of gravity. This together with the occurrence of stasis, favored by the smallness of the opening between the large and small intestines were in his opinion sufficient reason for the appearance of these tumors.

Meniere, Golbeck, Merling, Schmidt, Albers. In 1828, Ménière insisted that the disease was cecal in origin and that the inciting cause was impaction of feces. He felt that there was no connection between the iliac suppurative tumors and the vermiform appendix because: (1) there was no pus in the stools, and (2) no feces was found in the discharge from the external wound. Dupuytren agreed with Ménière. There can be no doubt that Dupuytren stood upon the brink of a great discovery and he entirely failed to appreciate the fact. Still worse, his lack of perception absolutely hindered the progress of investigation by depreciating the influence of the man whose insight had revealed the line which further research ought to pursue. However, reports of primary lesions in the appendix from then on increased year by year until the frequency rather than the rarity of the disease became generally admitted.

Until the third decade of the nineteenth century, interest was confined to England and France. Now Germany began to contribute her quota of observations. In 1832, Golbeck, a German, believed that the right iliac tumors were the results of collections of pus in the loose connective tissue about the cecum. He labeled the disease "perityphlitis." This euphonious term met with immediate general acceptance. The name perityphlitis is altogether misleading and diverted the attention from the real source of evil, clogging the wheels of progress for more than 50 years. The lay term for appendicitis during this period was "iliac passion" and the popular treatment was purging, bleeding and enemas. A very common practice was that of tobacco-smoke enemas!

In 1827, Merling suggested that pain and inflammation of the appendix may vary with the anatomical position of the organ. In 1847, Schmidt, writing on differential diagnosis of inflammation of the appendix, describes almost precisely what we know today as McBurney's point. It is interesting that although these early German writers between 1830 and 1860 described the symptoms accurately, they never ascribed them to their real source. No one appears to have entertained the suspicion that inflammation of the appendix was the real cause of the iliac tumors with which all surgeons at that time were frequently occupied. In 1838, Albers introduced another misleading term "typhlitis." This term as well as perityphlitis arises from the Greek, "typhlon," which refers to that portion of the intestine regarded now as the cecum. Albers points out that previous authors had not discriminated between this condition of "typhlitis" and inflammation *around* the cecum.

Hodgkin, Bright, Addison, Richards. Between 1830 and 1840 the well-known British contributions were made by Hodgkin, Bright, and Addison. In 1836 Thomas Hodgkin, a true follower of the great John Hunter, in his "Lectures on the Morbid Anatomy of the Serous and Mucous Membrane" says with remarkable clarity and brevity that "the partial inflammation of the peritoneum in the iliac fossa is sometimes set up by disease in the appendix caeci which may be limited or may go on to ulceration caused by the lodgment of fecal concretions in its cavity. Even in these cases, nature sometimes succeeds in limiting the inflammation to a part of the right side, but it is at other times diffused over the entire abdomen and is accompanied by the symptoms of a most serious nature and quickly proves fatal." Richard Bright and Thomas Addison, in "Elements of the Practice of Medicine," give an admirable presentation of the subject. They proved from numerous dissections that fecal abscesses which form in the right iliac region arose in a large majority of cases from diseases that began in the appendix

caeci. In treatment they advised: (1) unload the bowels by mild but effective purgatives assisted by injections of soap and water or gruel or other bland liquids so as to empty completely the large intestine, and (2) avoid violence in manual examination for fear of causing peritoneal extravasation of the abscess content. Had not vague speculation and false nomenclature altered the masterly outlines presented by these three men, the history of appendicitis might have been considerably different.

In 1837, Walcott Richards of Cincinnati, O., was the first to report an instance of disease of the appendix in the United States. This was a perforated appendix confirmed by autopsy. In 1846, Voltz pointed out the benefit derived from the opium treatment of perforations of the appendix. He insisted that constipation, the common concomitant of the disease, favored recovery and should be encouraged. In 1842, Rokitansky's work on pathologic anatomy appeared. He presented a brief but excellent section on the appendix and this represented the earliest systematic consideration of this organ from purely a pathologic standpoint. He was first to describe the dropsical condition of the appendix which we know today as a mucocele.

Hancock, Parker and Others. In 1848, Hancock (London) went beyond the time honored treatment of Dupuytren (incision for relief of a manifest tumor in the right iliac fossa). He was the first to operate successfully after making a diagnosis of inflammation of the appendix before any evidence of *fluctuation* could be found. In 1840–1850 the appendix became a theme of frequent discussions in pathologic societies in Great Britain and the United States, resulting in the publication of a number of isolated cases. In 1859, Laudet examined the appendix of all autopsies in his hospital and pointed out that perforation of the ileo-cecal appendix is in itself more common than all other perforations of any parts of the intestine. The obstacles to the earlier advance along the right paths toward elucidation of the true nature of disease of the appendix were: (1) the force of Dupuytren's authority, (2) misnomers such as perityphlitis, typhlitis, and typhlo-enteritis, and (3) the absence of satisfactory objective proof that the disease of the appendix began in the appendix itself and not in the cecum.

By the middle of the nineteenth century Dupuytren was gone. He died in 1835 and the bad nomenclature was beginning to be questioned. The literature of the period indicates a growing desire for better classification for disease of the right iliac fossa. From 1860 on, disease of the appendix began to become increasingly a question of surgery. Finally in 1886 Reginald Fitz, professor of pathology at Harvard University, cleared up the entire subject and initialed an epoch in medical and surgical history. It is interesting to note that this was the same year that Von Bergmann introduced steam sterilization. Fitz analyzed 466 cases, in 257 of which, the diagnosis was unquestionable, having been made post mortem. In the remaining 209 the diagnosis was made clinically of either typhlitis, perityphlitis, or perityphlitic abscess. Fitz had studied under both Rokitansky and Virchow. It was in his work that the name of *appendicitis* appeared for the first time, quite incidentally and without formal introduction. The remarkable feature of Fitz's work was the ease with which previously perplexing questions were resolved by the master hand into a simple clinical entity. The time was ripe, the man appeared, and surgeons needing the assurance of safety, gratefully accepted this transfer of responsibility from the domain of internal medicine. They then began to develop operative procedures for treatment of diseases of the appendix.

The evolution of operative procedures for diseases of the appendix had its inception in the early Christian era. As early as 50 B.C. Aretaeus described incision and drainage of the right iliac fossa abscess. In 100 A.D., Doranus of Ephesus reported evacuating a pus collection which was probably of ruptured appendiceal origin. Mestivier's case in 1759 was the first case where disease of the appendix was clearly recognized and it occurred during the incision and drainage of one of these right iliac fossa abscesses. From this date onward, these abscesses received increasing attention. Their treatment by the time honored, "incision at the point of fluctuation" was recommended and practiced by Dupuytren but the concept of incision of the right iliac tumors *prior to fluctuation* did not occur to Dupuytren or to his followers. In 1848, Hancock suggested surgical incision and drainage *prior* to the presence of fluctuation. Hancock's initial case was a 30-year-

old woman who had symptoms suggestive of appendicitis in the fifth month of pregnancy. On the seventh day post partum she had repeat symptoms and a mass appeared in the right lower quadrant. With chloroform anesthesia, a four-inch incision was made from the spine of the ilium above Poupart's ligament and as close to it as possible. A large abscess with two fecal concretions was found. He argued strongly that fecal concretions found in the wound were convincing evidence that the abscess had started at the appendix. Nothing more, however, was heard of the surgical treatment of such tumors, in the absence of fluctuation, for nearly *20 additional years.*

In 1863, Willard Parker in New York advised that good results attended the early incision and drainage of these cases. He published a report on four cases and recommended that the fifth day was the earliest date for surgical intervention. The method which he pursued became widely known in the latter part of the nineteenth century and was known as the "Willard Parker operation." This was an incision six inches long through the skin commencing above and about one inch from the anterior-superior spine of the ilium and ran toward the symphysis pubis. A tent-type drain was inserted and the wound was left open to heal by granulation. The year following Parker's publication the prime obstacle for further advancement and treatment of the disease of the appendix was removed by the introduction of the principle of antisepsis. This evolutionizing method, although discovered and published in 1863 in France by Jules Lemaire, was also independently discovered and introduced into surgical practice by Lister in 1868. Evidence of the transformation taking place in the entire surgical field becomes more and more evident after this date.

In 1873, W. T. Bull in summing up the literature gave a list of all the cases treated by incision up to this date. Until this date only nine were made prior to the appearance of fluctuation. In 1875 a list by Goulay showed an increase of 28 cases of incision prior to fluctuation within only two years. By 1882, Noyes in presenting a similar list added 56 cases of *early incision.* It is of interest to note the reduction of the mortality rate from perityphlitis after the introduction of the Parker operation. In 1867 the death rate was reported by Parker to be 47 per cent. Fifteen years after the introduction of the Parker operation, 1822, the death rate was reported by Noyes to have dropped to 15 per cent. Up to the early 1880's incision and evacuation of pus in the presence of fluctuation was the most daring procedure anyone had ventured to propose. Gynecologists exploring the abdominal cavity with relative impunity at this time also furthered the knowledge of the disease of the appendix.

In 1880, Bouchard in New York recommended a posterior incision in order to reach the appendix. His incision was described as extending transversely from a point about two inches in front of the anterior border of the latissimus dorsi muscle forward about six inches, parallel to and just above the crest of the ilium. He suggested stitching the edges of the perforation to the base of the wound. In 1889, Lawson Tait advised a rather interesting operation. He suggested making a slit in the appendix and using a celluloid catheter, push the fecolith back into the cecum, the catheter was then removed three days later. This operation was advised in cases in which early surgical intervention was made. In 1884, Samuel Fenwick suggested cutting down directly upon the appendix as soon as the diagnosis was fairly well substantiated, placing a ligature about the site of the perforation and debriding the area. This suggestion represents the *end of the prelaparotomy period* in the history of appendix.

Mikulicz, Symonds, Hall, Morton. In 1884, Mikulicz introduced the principle that perforation of the stomach and intestines should be treated by opening the abdominal cavity, suturing the perforation and restricting the inflammation of the peritoneum by thoroughly washing out the abdominal cavity. In any peritonitis in which the original cause was not clear, he suggested that perforation of the appendix must be considered. In 1880, Mikulicz sewed up for the first time a perforation of a gastric ulcer. Unfortunately the patient died within three hours after the operation. To demonstrate the truth of his beliefs he subsequently operated upon a patient with a ruptured appendix, intending to remove the organ. However, he was unable to find the appendix and the patient died. In 1884, Kronlein performed the operation advised by Mikulicz for the first time. This was a case of a 17-year-old boy in whom an incision was made in the linea alba extending

from the umbilicus to the pubes and a perforated appendix was found. No localized abscess was noted and the abdominal cavity was washed out with a solution containing 2.5% carbolic acid. A double ligature was placed at the base of the appendix and a single ligature about the mesentery. The appendix was removed in toto. The boy improved for 24 hours and died three days later. No autopsy was performed. This report was not published until 1886 but still stands as the *first instance of laparotomy followed by removal of the appendix.*

In 1885, Symonds (England) described the first *interval* operation for disease of the appendix. He described removing a calcareous body from the region of the appendix. This is a poorly documented report and the exact nature of the operation is uncertain. It would appear on the surface that acute appendicitis was generally recognized prior to 1886. In examining several medical textbooks published between 1875 and 1885, there was no mention of appendicitis or that perityphlitis or typhlitis was considered as a result of appendicitis. In 1886, Fitz in a table of 60 fatal cases demonstrated that 34 per cent of the patients died during the first five days of the disease. Therefore, he felt that the earliest date fixed by Parker was too late to afford relief in more than one-fourth of all the cases. Fitz implied that the third day following onset of symptoms was a more justifiable choice.

In 1886, R. J. Hall performed the first operation on the appendix in the United States. The operation was undertaken for the relief of a strangulated hernia. The appendix was ligated above the perforation with catgut, the stump was disinfected with bichloride solution, and a rubber drain was placed in the pelvis. The wound was left open and the patient recovered. In 1892, Thomas Morton of Philadelphia claimed credit in the United States for the *first deliberate appendectomy.* He cleaned the peritoneal cavity with water at 110 F. and drained the pelvis. There were great deliberations regarding priority in this country during that period, and gradually the principle evolved that any claim to priority in medicine or surgery rests by the consent of the profession not upon the date of performance but upon the date of publication.

We have traced our subject through the successive stages of development from the first discovery of a lesion in 1759 to the time of Fitz, in 1886, who banished the older misleading terms of typhlitis and perityphlitis. We have reviewed the earliest efforts of surgeons at first timidly opening a few abscesses, a classical procedure, and then gradually growing bold enough to take the important step of making an incision before the detection of fluctuation (Hancock and Willard Parker). We have found a few surgeons, endowed with the courage from the development of antisepsis, venturing to open the peritoneum and straighten out a kink (Treve peritoneum and straighten out a kink (Treves in 1887), or to trim the edges of a fistula in the appendix (Sands in 1887), and at last to remove the entire organ (Kronlein in 1884, Morton in 1887, and Sands). During this latter part of the nineteenth century, appendicitis came into vogue in England and caused postponement of the coronation of King Edward VII in 1902. This operation was performed by Treves. In the United States, primarily, further evolution consisted of development of technique. Senn, who is described as a humorless domineering Swiss whom nobody liked, opened many new roads in surgery. In 1888, he disinfected the stump of the appendix and inverted it. He suggested that drainage of the properly closed stump was unnecessary and should be dispensed with.

McBurney, Fowler and Others. In 1889, C. M. McBurney dealt with the subject in one of the classics of surgery. McBurney described the location of the pain as a significant factor in making a diagnosis of appendicitis (McBurney's point). In his words he stated that "the exact locality of the greatest sensitiveness of pressure had seemed to me to be usually one of importance. Whatever may be the position of the healthy appendices found in the deadhouse and I am well aware that its position when inflamed varies greatly, I have found in all of my operations that it lay whether thickened, shortened, or adherent very close to the attachment of the cecum. This, of course, must in the early stages of disease determine the seat of greatest pain on pressure and I believe in every case the seat of greatest pain determined by pressure of one finger has been varied exactly an inch and a half and two inches from the anterior spinous process of the ilium on a straight line from that process to the umbilicus. This may appear to be an affec-

tion of accuracy but so far as my experience goes the observation is correct." During this early period of development and treatment of appendicitis, George Fowler, who was professor of the New York Poly Clinic Medical School and developed "Fowler's position" for abdominal surgery, himself died of appendicitis. Some of the prominent names in this era of popularization of appendectomy were Maurice Richardson, Riedel, and Marcy in this country. In 1895, Battle in London described the "Battle's incision" for appendectomy which is a vertical incision near the midline.

Until the past two decades the dominant school of therapy was that popularized by A. J. Ochsner and his ideas were presented as he delivered the chairman's address at the annual meeting of the American Medical Association in 1901. He felt that appendectomy as an elective operation had been greatly over emphasized. He suggested that bed rest, opium around the clock, nothing by mouth, and fluids per rectum were the treatment of choice. This was known as the "expectant treatment," awaiting a well-defined abscess to form which was to be drained within 10 days of the initial onset of the attack. He also maintained that time favored the development of an immune response, that antibodies would form against the affecting organisms.

J. B. Murphy, described as a temperamental Irishman of Chicago, (a graduate of Rush Medical School, later studied under Billroth) held the opposite view, referring despairingly to the Ochsner method as the "expectant mortans regimen." In 1889, he presented 100 cases of operation in early appendicitis and suggested there were never any complications in appendicitis if the patient were operated within the first 12 to 24 hours of onset of symptoms. J. B. Murphy further described the orderly sequence of symptoms as diagnostic in appendicitis. He demanded nothing less than removal of the appendix upon a well-founded suspicion of inflammation; to eliminate the possibility of disease by cutting out its source. He rapidly became the most sought after surgeon in Cook County Hospital.

Summary. Appendicitis occupies a unique position in the history of medicine and surgery. It evolved from an unknown entity in the mid-nineteenth century to one which is fully understood to the point of being relegated to a minor role in current medical problems. The remarkable feature is that this is a well-documented story and in this respect yields considerable insight into the current of philosophy underlying progress in medicine.

1912 Atwood Avenue (4).

NEW PATHOLOGY SLIDE FILM

The vital role of the pathologist in maintaining the nation's health is described in a new slide film which was premiered in Washington, D. C. in August before the American Association of Blood Banks. Entitled "What is a Pathologist," the 15-minute film outlines the training and duties of the pathologist as well as his close relationship with clinical physicians in determining the precise diagnosis and treatment of disease.

The film is the twentieth in a series of teaching films sponsored by the Commission on Continuing Education of the American Society of Clinical Pathologists. The films are designed to keep the practicing pathologist abreast of the latest scientific developments in his field. Dr. Robert W. Coon, president of the organization and professor of pathology of the University of Vermont, narrates the new film.

The presentation was supported by a grant-in-aid from the General Diagnostics Division of Warner–Chilcott Laboratories and was produced by Synergist Productions of New York. Prints of "What is a Pathologist" will be supplied to medical schools and state pathology organizations for showing to various student and civic groups.

ANTIRHEUMATICS

The multiplicity of "new" and/or "improved" analgesic-anti-inflammatory preparations indicates that the perfect product has not been found. Recent additions to the multipurpose drug list include the following:

DMSO. In its first clinical trials at the University of Oregon Medical School, DMSO (dimethyl sulfoxide) has come through with flying colors. A single application of the compound gave "quick relief" in "excruciatingly painful" bursitis and "encouraging initial results" were noted in repeated applications for the relief of rheumatoid arthritis and osteoarthritis. The drug relieves pain and prevents blister formation in second degree burns and provides symptomatic relief in chronic sinusitis. In addition to its remarkable analgesic and anti-inflammatory properties, DMSO possesses a remarkable ability to transport other drugs through the skin barrier and across cell membranes. Its mechanism of action is under investigation.—Reprinted from *International Medical Digest*, April 1964.

Herpes Zoster with Involvement of the Urinary Bladder

CASE REPORT

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■ HERPES ZOSTER (creeping girdle) has been recognized as a clinical entity since the time of Celsus. It was called "zona" by the Greeks and "holy fire" by the Romans.[1] In 1818 Mehlis pointed out its association to peripheral nerves, and Bärensprung in 1861 described its relation to the dorsal-root ganglions.[1]

Herpes zoster produces an inflammatory reaction in the dorsal roots and ganglions, meninges, and the posterior horn of the gray matter. The virus may extend into the anterior horn with motor paralysis (poliomyelitis). Classic cutaneous lesions and occasional findings of inflamed leptomeninges result from this inflammatory reaction, which may extend peripherally, centrally, or in both directions.

The cutaneous lesions are usually one-sided and follow a segmental distribution corresponding to the spinal roots involved. Zoster has been known to affect the skin in widely separated areas, even on opposite sides of the body, and a cutaneous rash does not always occur. When the lesions involve the bladder, they appear cystoscopically as papulovesicles and ulceration occurs before healing. Present evidence strongly suggests that herpes zoster and chicken pox are caused by the same virus.

Head and Campbell,[2] unaware of the etiology of herpes zoster, considered the disease acute posterior poliomyelitis. Extensive involvement of the spinal cord, including motor neurons, has occurred, as described in 1924 by Lehrmitte and Nicholas,[3] who called the condition "La Myélite Zostérienne." Findings indicative of leptomeningitis may be demonstrated in the cerebrospinal fluid. Paralytic manifestations of herpes zoster were recognized by Broadbent[4] in 1866, and many instances of motor phenomena have been reported.

Visceral as well as somatic sensory nerves may be affected with the production of symptoms referable to the organs innervated by the involved nerves. When pain precedes the cutaneous lesions, the subjective symptoms may simulate organic disease, such as ureteral colic, pleurisy, myocardial infarction, peptic ulcer, and peritonitis.

In a review of 131 cases of herpes zoster, Gais and Abrahamson[5] reported visceral manifestations in 42. In 6 of these they considered the genitourinary system apparently involved as indicated by the symptoms of costovertebral-angle pain, dysuria, frequency, and hematuria. The absence of urinary retention in this series was explained by the fact that the lowest level of involvement was the fourth lumbar segment; vesical dysfunction theoretically necessitates the involvement of the second, third, and fourth sacral segments. However, as previously pointed out, there may be more extensive involvement of the spinal cord without cutaneous lesions to indicate a level, and the first lumbar nerve does receive a branch from the twelfth thoracic.

Dubois[6] observed a man in his late forties with herpes zoster of the left buttock. Three days following the appearance of the rash he developed frequency, dysuria, and urinary retention. Cystoscopy revealed vesicles on the left bladder wall. The urinary symptoms persisted for 10 days. The mucosal lesions of the bladder and the skin lesions disappeared at approximately the same time.

Reports by Gibbon,[7] Wyburn-Mason,[8] and others[9-12] indicate that the literature contains some 25 cases of urinary retention and lesions of the bladder secondary to herpes zoster.

The nerve supply of the urinary bladder and the mechanisms involved in the act of micturition are complex. The efferent nerve

From the Departments of Urology (Doctor Ewell) and Internal Medicine (Doctor Straughn), Jackson Clinic.

supply comes from the sympathetic (lumbar segments, first and second) and the parasympathetic (nervi erigentes) from the sacral, first and second. The genitofemoral nerve is formed by the first and second lumbars.

Case Report. An 89-year-old woman was admitted to the hospital in May 1961, because of a rash on the upper right abdomen and lateral chest wall extending almost to the midline posteriorly and severe pain in the right abdomen and right chest. There was also pain in the right thigh, hip, and back. The rash and pain had been present for four days. Her history disclosed that in March 1961 she developed coryza, which was followed by bronchitis and bronchopneumonia said to be viral in nature; this respiratory illness lasted approximately four weeks. Her temperature, which on admission was 100.1 F. and rose to 102 F. on the second hospital day, subsided to normal in a week and remained relatively normal for the duration of her stay. The rash was typical of herpes zoster involving the chest wall and the abdomen in the area of distribution of the tenth, eleventh, and twelfth thoracic nerve segments.

Laboratory examinations revealed a white blood cell count of 5,100 per cu. mm. with a differential count of 48 neutrophils, 50 lymphocytes, and 2 nonsegmented cells. The lymphocytes appeared normal. The hemoglobin level was 11 Gm. per 100 ml.; hematocrit reading 36%; red blood cell count, 4,300,000; blood urea nitrogen, 20 mg. per 100 ml. Urinalysis showed specific gravity, 1.013; reaction, 5.5pH; 0–2 white blood cells and 10–12 red blood cells per high-power field; albumin and sugar, negative; and acetone, 1+.

On her first hospital day she complained of abdominal distention and inability to defecate during the prior three days, for which she received enemas with poor results. Rectal examination did not reveal stool. On her first and second hospital days she reported that she had voided satisfactorily.

At this time she complained very much of pain in the herpetic area and was mentally confused. Her mental confusion was considered to be due in part to the medication necessary for relief of pain and nervousness, although the medication should have had no influence on the urinary bladder: dextropropoxyphene and acetylsalicylic acid compound (Darvon Compound–65) as needed; neostigmine, Prostigmin), 1–4000; chloral hydrate (Noctec), 0.5 Gm. at bedtime. On the fourth hospital day, because of weakness of the legs, she required assistance to get out of bed and into a chair and to the bathroom. She reported that she voided what she considered a large quantity of urine.

Examination again at this time disclosed marked weakness of all the leg muscles, although no demonstrable changes in the reflexes. The bladder was found to be distended, a Foley catheter was inserted, and 1,050 ml. of residual urine obtained.

The weakness of the legs persisted; however, five days later she was able to get out of bed and stand up with assistance. The weakness persisted for 10 to 12 days.

Her past history of vesical function disclosed frequency of urination for several years and nocturia three or four times. There had never been any dysuria or difficulty, and she had never sought medical attention for urinary disturbances of any type.

On the fifth hospital day and on occasions thereafter the Foley catheter was removed; however, the patient was unable to void and the catheter was replaced. She was given bethanechol chloride (Urecholine) by mouth. In the meantime her bowel function had improved.

The Foley catheter was reinserted and continuous drainage instituted. On the twelfth hospital day cystoscopy, without anesthesia, revealed grade 3 polypoid and granular urethrotrigonitis, a grade 2 cystocele, and grade 1 diffuse congestion and granular inflammation of the entire bladder mucosa. No vesicles or ulcerative lesions involving the right bladder wall were visualized. The bladder was filled with 750 and 950 ml. of saline solution without producing any desire to void; 750 ml. of water was left in the bladder and the instrument removed, but the patient was unable to void.

On the nineteenth hospital day a Foley catheter was replaced and a cystometrogram attempted, which was unsatisfactory. Tidal drainage was instituted.

Following a week of tidal drainage, a cystometrogram was repeated and again was unsatisfactory. The bladder capacity was large, over 1,000 ml. There was only minimal intravesical pressure with voluntary efforts at straining, although the patient was somewhat confused about the act of straining to void.

Tidal drainage was continued and on the thirty-third hospital day, the Foley catheter was removed. The patient indicated a desire to void on several occasions during the day but was unable to do so. The catheter was replaced and 550 ml. of urine obtained. On the thirty-ninth hospital day a cystometrogram was again attempted and again was unsatisfactory.

On the forty-sixth hospital day the Foley catheter was again removed. The patient voided a small quantity of urine on one occasion, and 400 ml. of residual was obtained. The Foley catheter was replaced. She was again given bethanechol chloride by mouth. On the forty-eighth hospital day the Foley catheter was removed and again she was unable to void. It was reinserted and removed again on the fifty-third day and again replaced in the late afternoon, as she had no desire to void, and 450 ml. of urine was obtained.

On the fifty-fifth hospital day the catheter was removed at 10 a.m., and at 5 p.m. she voided 30 ml. and subsequently amounts of 100, 225, and 200 ml. On the two following days she voided without difficulty or dysuria of moment in amounts of approximately 125 ml.; however, on each of these two days, following voiding, as much as 200 ml. of residual urine was obtained per catheter in several instances.

She was discharged from the hospital on the fifty-seventh day following her admission and seen in the clinic at frequent intervals. As far as she was concerned, she considered her bladder function satisfactory, although at each visit to the clinic amounts of residual varying from 50 to 100 ml. were noted; during the month of August 1961, the amounts of residual averaged around 100 ml. gradually decreasing during September and October with gradual decreasing frequency and nocturia and minimal amounts of residual. She considered her bladder function good.

She developed a typical severe type of postherpetic neuralgia, which responded slowly but steadily to tetraethylammonium chloride (Etamon), and the urinary infection steadily improved with continued medication.

Summary. A review of the literature reveals only 25 cases of urinary retention and lesions of the bladder secondary to herpes zoster.

We have presented another case of severe herpes zoster with urinary retention and prolonged vesical dysfunction.

Without whatever evidence may have been contributive to the diagnosis by examination of the spinal fluid, which we chose to defer, it is our opinion there was sufficient clinical evidence and physical findings to substantiate the diagnosis of involvement of the spinal cord by the herpes virus producing a neurogenic type of vesical dysfunction. Overdistention paralysis due to the residual urine during the early admission days, in our opinion, was only a minor contributing factor to the prolonged period of vesical dysfunction.

30 South Henry Street.

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UNIVERSITY OF WISCONSIN MEDICAL CENTER "Grand Rounds" sessions started in September. Details can be found on page 42 of this issue.

CLINICOPATHOLOGIC CONFERENCE

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C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: GEORGE C. BARES, M.D.
Milwaukee, Wisconsin

Case Presentation.* The patient was a 60-year-old woman who entered the hospital on December 6 with the chief complaint of pain in the arms and legs and a history of 10-lb. weight loss in the past few months. She was a divorced housewife with two grown children and had recently been employed as a machine operator. There was no history of exposure to industrial toxins.

The physical examination on admission revealed a pale and sick-appearing white woman whose temperature was normal, pulse 100 and regular, blood pressure 120/80 mm. Hg. The teeth were in poor repair, and slight enlargement of the anterior and posterior cervical lymph nodes was noted. The heart exhibited a rate of 100 with an occasional extra systole and a to-and-fro murmur at the apex. The liver was palpable three fingerbreadths below the right costal margin. Auscultation of the lungs and abdomen revealed no abnormalities. A few palpable nodes were detected in the inguinal region. A neurologic examination revealed profound weakness of both upper and lower extremities with no abnormal reflexes and no limitation of motion. Vibratory senses were absent in the left lower extremity and diminished on the right and in both upper extremities.

Laboratory studies on admission showed a white blood cell count of 10,000 per cu. mm., hemoglobin level 8.2 Gm., and hematocrit reading 23.5%. The Schilling differential exhibited 54 segmented cells, 5 stab forms, 6 lymphocytes, 2 monocytes, and 33 eosinophils. Sedimentation rate was 132 mm. at one hour (Westergren). The urinalysis revealed a trace of albumin, normal specific gravity, 5 to 10 white blood cells and 2 to 4 red blood cells per high-power field (voided specimen). Repeated complete blood cell counts showed persistent anemia and eosinophilia up to 52%. Gastric analysis exhibited free hydrochloric acid. Lupus erythematosus (LE) preparations were negative. Serum iron was 29.0 μg.; iron binding capacity 244 μg. Serum electrophoresis showed albumin 37.5, alpha 1 globulin 7.2, alpha 2 globulin 15.1, beta globulin 8.6, gamma globulin 31.6, with a total protein of 6.70 Gm. per 100 ml.

X-ray film of the chest showed essentially normal lungs with slight haziness over the apices bilaterally which was not apparent on lateral projection. Gastrointestinal series including barium enema revealed no abnormalities. No skeletal lesions were detected. Electrocardiographic studies exhibited no abnormalities.

The patient showed very little improvement while in the hospital. Her appetite remained good, but her complaints of weakness and pain in the extremities continued. A bone marrow examination performed on December 9 exhibited a marked eosinophilia but no other significant change. Following completion of the laboratory studies, four units of sedimented red cells were given, followed by some improvement in the patient's clinical condition and an elevation of the hemoglobin level to 11.8 Gm. Vitamin B-12 was given intramuscularly for the apparent neuritis. On December 20 lymph node biopsies were taken from the left posterior auricular area and right inguinal region. These exhibited no unusual change.

On December 25 the patient experienced a sudden onset of severe left upper quadrant, intermittent, cramping pain commencing shortly after her evening meal. When seen she complained of generalized aches and pains and stated there had been no bowel movement for two days. She felt nauseated but there was no vomiting. The blood pressure was 72/60 mm. Hg. with a pulse rate varying up to 140. Respirations were 40 per minute and the temperature 97.6 F. The skin was cold and there was mild diaphoresis. The chest was clear, and the heart exhibited no detectable murmurs. The abdomen was moderately distended with marked guarding,

* From Misericordia Hospital.

pain, and rebound in the left upper quadrant. The bowel sounds were high-pitched, but there were no rushes or tinkling sounds. There was marked left costovertebral angle tenderness.

The patient was started on vasopressors, and later in the evening she experienced several episodes of vomiting. Her shock-like state persisted, and after six hours she died.

Clinical Discussion. *Dr. W. L. Coffey, Jr.:* The complaints on admission, pain and weakness in the extremities and weight loss, are rather nonspecific in a patient of this age. Her physical examination showed a few significant changes, but it is questionable in what way they related to her underlying condition. The pulse rate of 100 could well be due to excitement, and the blood pressure was normal. Enlargement of cervical and inguinal lymph nodes, although possibly significant, does not appear to be particularly remarkable as borne out by the subsequent biopsy examination. The murmur at the apex, which was described by one observer to be to-and-fro type, is a little difficult to interpret but would suggest both regurgitation and stenosis, and although unusual, must be considered.

Although the liver was noted to be enlarged, there was no mention made of tenderness and no apparent suggestion of nodularity. Both physical and x-ray examination of the chest revealed no significant finding. The neurologic changes are interesting but again difficult to interpret. In any event these changes suggest the likelihood of posterior cord involvement such as seen in tabes and pernicious anemia with subacute combined degeneration.

The laboratory data reveal a number of interesting changes. We see a significant anemia and eosinophilia. My initial impression is that this is probably an iron-deficiency or blood-loss type of anemia which is borne out by the subsequently reported serum iron and iron-binding capacity. The sedimentation rate, although elevated, loses its significance in the presence of the profound anemia. The urinalysis shows some questionable findings, and although suggestive, I feel the normal specific gravity and the small number of white and red blood cells, particularly in a voided specimen, would indicate reasonably adequate renal function. The serum electrophoresis offers considerable information with relatively decreased albumin and significantly increased gamma globulin. It appears that the improvement seen in the patient following transfusion is related primarily to increased oxygen-carrying capacity and that the vitamin B-12 injections were given empirically for the neuritis with no notable improvement.

The examination of the bone marrow is again interesting, but appears to offer no particular help in concluding a particular disease entity. The positive free hydrochloric acid and negative LE preparations similarly were of negative value. Following the onset of the acute and final episode, it is reported that the heart sounds were essentially normal with no evidence of murmur, which leads me to believe that the earlier observation of a to-and-fro murmur was not particularly significant and was probably confused by the somewhat rapid heart rate and the profound anemia. The terminal event was certainly dramatic, and I am sure was related to the underlying disease process. The rapidity of onset with the persistent lowering of blood pressure is suggestive of a severe intra-abdominal catastrophe.

Differential Diagnoses. The effort then must be made to correlate the findings, as much as possible, in terms of a single disease entity. With all of the changes present, several appear to be significant. Among these are weight loss, neuritis or polyneuritis, hepatomegaly, iron-deficiency anemia, marked eosinophilia, and alteration of the serum proteins with elevation of the gamma globulin. The weakness of the extremities was accompanied by pain, and for this reason I do not feel that the weakness was entirely due to weight loss. The disturbances in the extremities do not appear to be due to arthralgia but principally seem to be that of a polyneuritis. The anemia was certainly significant, but there are no changes present either on the hospital examination or in the history that would adequately explain it. I would assume, however, that there probably was cryptic blood loss.

The alteration of the serum proteins with reduction in albumin and increase in globulin gives rise to several possibilities that must be considered, first of which would be liver dysfunction and the other malabsorption. Neither of these is well supported by the history or the subsequent events. Similarly dysproteinemia due to urinary tract loss of protein does not appear to be a likelihood in view

of apparently adequate kidney function and minimal proteinuria. The elevation of the gamma fraction suggests several diseases, namely, disease of the musculoskeletal system, the various collagen diseases, and multiple myeloma. I will exclude the latter possibility on the basis of negative x-ray and bone marrow findings. One might suggest the possibility of Boeck's sarcoid in discussing dysproteinemia, but again there is no adequate clinical or laboratory evidence to suggest this. With all of the possibilities that can be listed as causing dysproteinemia, I feel that this single alteration cannot be taken by itself for diagnostic purposes, and consideration must be made in the light of other changes present.

The first of these which I feel is significant is the pronounced eosinophilia which suggests some form of hypersensitivity reaction or allergic state. I feel that exogenous allergens can be ruled out here which brings us to the autoimmune states, particularly the collagen or so-called collagen diseases. The arthralgia and polyneuritis would also fit into this category. Disseminated lupus erythematosus, although not completely ruled out by negative LE preparations, can be put aside for the time being. There are no apparent skin changes present to suggest scleroderma or dermatomyositis. The muscle weakness, weight loss, and neuritis are certainly suggestive of multiple system disease. It is also possible, with multiple system disease or necrotizing angiitis, to have cryptic blood loss from the gastrointestinal or the urinary tract.

Although there appears to be some confusion in the classification of the collagen diseases, the alterations presented are strongly suggestive of what has been commonly called periarteritis nodosa. We have no biopsy changes to support this diagnosis, and one wishes that at the time of lymph node biopsy a muscle biopsy could have been procured. It might have provided us with a clear-cut clinical diagnosis. The profound anemia and eosinophilia, although not constant in periarteritis, are consistent with this disease.

The final episode appears to have been some form of vascular accident with either massive thrombosis or disruption of a blood vessel, both of which could occur in polyarteritis. In conclusion then I feel that the clinical and laboratory findings are most strongly suggestive of a collagen-type disease, most likely polyarteritis nodosa.

Dr. T. C. Puchner: Was there any temperature elevation during the course of the patient's stay in the hospital?

Dr. George C. Bares: There was a low-grade fever of intermittent type.

Doctor Puchner: Then Hodgkin's disease was considered?

Doctor Bares: Yes.

Doctor Puchner: I presume pernicious anemia was considered in view of the initial blood picture and neuritis?

Doctor Bares: Pernicious anemia was ruled out shortly after the patient's admission.

Doctor Puchner: I think Doctor Coffey's approach to this problem was very logical in view of the information available. The multiple organ involvement with lack of specific change certainly points to collagen disease and more particularly to polyarteritis. All of the changes present, namely a slight rise in temperature, weight loss, weakness, eosinophilia, increased sedimentation rate, and elevation in globulin, point more towards a hypersensitivity state than to any other type of condition. The peculiar murmur heard on admission is an interesting finding, and I do not feel it is inconsistent with the diagnosis of polyarteritis.

It is well known that myocardial and coronary artery involvement are both fairly common in polyarteritis. These changes, particularly if they are of progressive or regressive type, with the anemia, could certainly give rise to bizarre murmurs and significant changes in the character of murmurs from one time to the next. Whether the observation of this was truly a to-and-fro murmur at this point is immaterial. The very fact that a murmur was noted at one point in the hospitalization and absent at another point is the significant feature. However, I am surprised at the lack of electrocardiographic changes in this patient. But again these could be transitory changes, and at the time the cardiogram was taken no significant alterations were apparent.

Gastrointestinal lesions are quite frequent in polyarteritis; and although there was no bleeding apparent in this patient, it is conceivable that there was blood loss from the gastrointestinal tract. The amount of blood found in the urinalysis does not appear to be of sufficient magnitude to produce such a profound anemia. In my opinion lack of notable genitourinary tract and pulmonary lesions

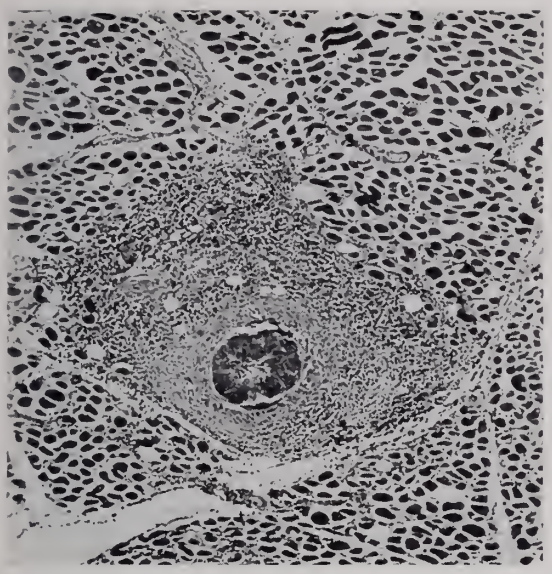

Fig. 1—Myocardial artery showing necrosis of wall, narrowing of lumen, and extensive periarterial leukocytic infiltration.

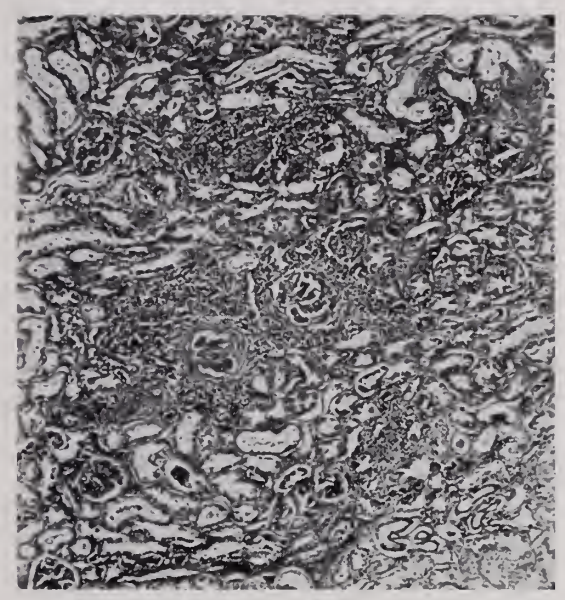

Fig. 2—Glomerular changes and surrounding inflammatory cellular infiltrate.

sufficiently excludes Wegener's granulomatosis.

Dr. T. L. Calvy: Had the patient been on steroids at all or at any time?

Doctor Bares: No.

Dr. Philip Guzzetta: I was particularly interested in the terminal event from the surgical standpoint. The picture was that of a massive vascular insult, and I was reminded of one of my patients on whom I performed surgery with a similar episode. In this case the patient subsequently was proven to have periarteritis. At operation we found a massive hemorrhage of one kidney which actually disrupted the capsule. Recalling this experience I wondered whether this was the possibility here.

Pathologic Discussion. *Doctor Bares:* It appears that all of the participants are in accord, and I want to congratulate Doctor Coffey for arriving at the correct diagnosis. At autopsy, the prominent changes were those surrounding the terminal events. There was a broad disruption of the left renal artery with dissecting hemorrhage upward toward the spleen. The gross alteration of the renal artery appeared to be more of a necrotic process than one would expect with disruption of an aneurysm.

Microscopically, many organs were involved in varying degrees by changes typical of acute polyarteritis or necrotizing angiitis. All of the involved vessels exhibited similar alterations characterized by thickening and degeneration of the media, loss of internal elastic lamina, and destruction of intima with thrombotic material within the lumina of most arteries. In addition, there was intense acute inflammatory infiltrate within and around all of the involved arteries. No arteries showed early degenerative change and nowhere was there a suggestion of healing or fibrosis.

The most extensive arterial involvement was seen in the heart accompanied by surprisingly little myocardial damage. The largest artery found to be involved was the left renal where there was extensive necrosis of the wall at many levels. Less extensive arterial and arteriolar involvement was found in the liver, gastrointestinal tract, spleen, spinal cord, and periadrenal fat. The kidney showed notably little arterial involvement. Here, however, there was distinct alteration of the glomeruli with hyaline thickening of the capillary tufts and Bowman's capsule with many dense aggregates of segmented neutrophils about the involved glomeruli.

Final Diagnosis. The entire picture then is that of an acute and rapidly progressive necrotizing angiitis or polyarteritis (nodosa) with multiple system involvement. The terminal event was disruption of a major artery with massive hemorrhage.

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COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Treatment of Acute Mercury Poisoning

By JAMES L. WAY, Ph.D.
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■ ALTHOUGH THE incidence of acute mercury intoxication is relatively rare, it is quite lethal in a high percentage of cases unless intensive treatment is promptly instituted. The signs and symptoms of acute intoxication are more varied than the chronic intoxication, and are dependent upon the type of mercury compound and the route of administration. These toxic effects of mercury are presumably attributed, in general, to its property as a general protoplasmic poison by combining with sulfhydryl groups. The advent of dimercaprol (British anti-lewisite) during the second World War has greatly improved the treatment of acute mercury poisoning.

Organic mercurial compounds are probably the most frequent cause of acute mercury intoxication. These compounds are employed as economic poisons in industrial processes and as medicinal agents. Some of the organic mercurial compounds are volatile, and inhalation of the organic mercurial vapors can exert violent toxic effects which are referable principally to the neurological system, but also to the renal system. Administration of dimercaprol is followed in some cases by quite dramatic recovery, while in other cases the treatment of organic mercurial poisoning by this antagonist seems relatively ineffective.

One of the most common inorganic mercurial compounds which is involved in acute intoxication is mercuric chloride. It has been clearly shown that vigorous treatment with dimercaprol is life-saving. Additional ancillary treatment of acute mercurial intoxication would include: treatment of shock, relief of pain, stomach lavage with raw egg white and milk, maintenance of water and electrolyte balance, antibiotics, and close supervision of the patient for two weeks after exposure.

Although the incidence of acute intoxication by the inhalation of metallic vapor is very low, fatal inhalation of metallic mercury vapor by children as well as adults in industrial environments has been reported. After a short latent period following exposure, shortness of breath, chest pains, and fever develop. It should be pointed out that mercury vapor in high concentration possesses not only the usual toxic effects of mercury, but also it exerts an effect on pulmonary tissues. In these cases the administration of dimercaprol seems to be advantageous. If pulmonary involvement occurs, ancillary treatment with oxygen, corticosteroids, and antibiotic therapy may be administered.

For maximal effect the dimercaprol should be given as soon as possible at an initial dose of 5 to 6 mg. per kg. of body weight. One half the initial dose should be repeated two hours later and subsequently for four consecutive doses at four-hour intervals. Injections of dimercaprol should be continued at the latter doses twice daily for 10 days. It is important to continue the administration of dimercaprol for 10 days even when recovery is apparently complete. If the signs and symptoms of mercury intoxication are still present after 10 days, dimercaprol should be continued until recovery is complete or analytical data indicate that little mercury is present in the urine.

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SPECIAL TO THE JOURNAL

Medical Evidence in Disability Evaluation

By W. P. CROWLEY, JR., M.D.
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■ ALMOST EVERY physician in the State of Wisconsin has had or will have some contact with the Disability Insurance Benefits program of the Social Security Administration. He may advise a patient to claim such benefits; he may be asked to submit medical information to support his patient's claim; or, he may be asked to perform a medical consultation by the State Agency which cooperates with the Social Security Administration in evaluating these claims. Therefore, it should be helpful to the physicians in the State of Wisconsin to understand this program thoroughly and the type of medical evidence that is needed in disability evaluation.

During the next 12 months Wisconsin physicians will furnish about 18,000 medical reports on behalf of the 9,000 Wisconsin residents who are expected to apply for disability insurance benefits. Judging from past experiences, about 2 out of 3 of these people will be found disabled. They will join the 14,600 disabled Wisconsin workers and 10,300 of their dependents who are currently drawing social security disability benefits at the rate of $1¾ million a month.

Just 10 years ago protection against the risk of lost income due to disability was first added to the social security program. In 1954 the law was changed to "freeze" a disabled person's social security earnings record, so that years of no earnings or low earnings due to his disability would not be counted in determining his eligibility to future old-age and survivor benefits or in computing future benefit amounts. Two years later Congress provided cash benefits for disabled workers and their dependents. Benefits are now also payable to disabled adult sons and daughters of retired, disabled, or deceased workers, if the child's disability began before age 18.

DEFINITION OF DISABILITY

The Social Security Act defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. A medical condition severe enough to prevent gainful activity must exist for at least six months before benefits are payable.

The phrase "inability to engage in any substantial gainful activity" means that a person must be disabled not only for his usual job but also for any substantial work, even though such work may be different from or perhaps not as remunerative as his former work. Substantial gainful activity is regarded as the performance of significant duties for profit over a reasonable period of time. A condition is deemed to be "of long-continued and indefinite duration" if it has existed for at least six months and no approximate date of improvement or recovery in the future can be determined with reasonable certainty. In addition, an individual cannot meet the definition of disability if it is possible, with reasonable effort and safety, to achieve recovery or substantial reduction of the symptoms of his medical impairment by medical or surgical treatment. Such treatment must be readily available to the applicant and accepted by physicians in his community; it must not involve a significant risk to the applicant's life or health, so that a reasonably prudent man could be expected to accept such treatment. In addition, it must be reasonably expected to result in improvement in the impairment to the extent that the applicant will be able to engage in substantial gainful activity.

EVALUATION PROCESS

Authority to make decisions of disability is vested by the law in an agency of the State in which the applicant resides. Since it was the expressed intent of Congress that there be close coordination between the disability and rehabilitation programs, the State agency that determines whether social security applicants are disabled is usually the State Vocational Rehabilitation Agency. In Wisconsin a special disability determination unit was established within the Vocational Rehabilitation Division to make disability determinations. In addition to determining issues of disability, the Wisconsin Vocational Rehabilitation Division also considers all medical and vocational information from a rehabilitation viewpoint to decide whether to offer the applicant rehabilitation services.

Nine physicians, serving on a part-time contract basis, work with vocational specialists on two-man teams that determine disability. These physicians do not see the applicant but work from the medical information provided by the applicant's physicians, hospitals, and other sources of medical information. It is the physician's job to ascertain whether the evidence in the file is sufficient for him to independently confirm the diagnosis and reach realistic conclusions concerning the claimant's remaining physical and mental functional capacity. He must also determine from the clinical data at what point in time the claimant's impairment prevented him from working.

In those instances in which significant functional capacities are retained, the vocational expert evaluates whether the applicant could perform his former job with his present remaining physical and mental

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capacity, what skills from former employment could be transferred to a new, less demanding job, and whether employment opportunities exist for the types of work that the applicant might do. In this vocational evaluation the applicant's age, education, and previous work experience are carefully considered.

An applicant applies for disability benefits in the district office of social security nearest his home. At this time he is interviewed by a social security representative. In this interview, the applicant expresses in his own terms the nature of his impairment and how it prevents him from work. He also indicates the details of his previous work experiences, his education, and his daily activities. The interviewer includes his own observations of the applicant. The representative then helps the applicant request medical information and he may forward the forms to the applicant's physicians, hospitals, and other medical sources. When this information has been assembled, all of the material is forwarded to the Disability Determination Unit of the Vocational Rehabilitation Division in Madison.

If the medical information is adequate to permit adjudication, a written decision is prepared by the evaluation team in the State agency. Disability determinations are reviewed in the central office of the Social Security Administration in Baltimore, Maryland. The purpose of this review is to assure uniform adjudication of these claims nationwide. If the medical information is not adequate to determine whether the claimant is disabled or if there are conflicts between various sources of information, the State agency may contact the claimant's own sources by telephone or letter for additional information or clarification. If the additional information needed to make a sound decision is not obtainable by these means, a consultation may be purchased at Government expense, from a physician in private practice according to a fee schedule agreed upon by the Vocational Rehabilitation Division and the State Medical Society of Wisconsin.

If a person is dissatisfied with the initial determination made in his case, he has the right to ask for a reconsideration of his claim. At this time he may present additional medical information, if he so desires. The claim is then reviewed by a new evaluating team in the State agency and in the Social Security Central Office. If the claimant is also dissatisfied with the results of the reconsideration, he may ask for a hearing before a Hearings Examiner of the Bureau of Hearings and Appeals. At this time the applicant may appear personally and may be represented by counsel. Testimony may also be taken from reporting physicians, consultants, and vocational experts. The Hearings Examiner makes a decision independent from that reached by the Disability Determination Unit. A further appeal is possible to the Appeals Council in Washington. The decision of the Appeals Council may be appealed to a Federal District court for a judicial review of the case to determine whether substantial evidence supports the decision.

MEDICAL EVIDENTIARY REQUIREMENTS

From the foregoing it is apparent that the medical impairment is the sine qua non of a favorable decision in a disability claim. The five major categories of illnesses that produce disability of sufficient severity to prevent gainful activity are cardiovascular conditions, respiratory diseases, the arthritides, neurological impairments, and emotional illnesses. To illustrate the type of medical evidence that is necessary for fair adjudication of these claims, a discussion of several of them in more detail is presented.

Cardiovascular and Respiratory Impairments. The cardiovascular and respiratory diseases generally limit an individual's functional capacity by the production of dyspnea, angina, or congestive heart failure. Since many of these conditions develop gradually, there is a period of time in which a wage earner can continue to work despite their presence. At some point in time, however, dyspnea, or chest pain will become sufficiently severe to limit the applicant's ability to walk, climb, lift, carry, and the like, so that he can no longer engage in gainful activity. In reporting such an illness it is most helpful to have a historical review, indicating when the illness first became apparent and when any significant changes occurred. In addition it is necessary to indicate how much exertion is required to produce these symptoms, since this will indicate the maximum effort an applicant can make in a work situation. Chest pain should be described as to its character, location, radiation, relationship to exertion or other precipitating factors, frequency of occurrence, duration and response to rest and nitroglycerin. These details concerning chest pain permit the reviewing physician to confirm that it is, indeed, anginal in character. The report of a physical examination should include blood pressure readings, determination of pulse rate, a description of any irregularities of cardiac rhythm, a statement that dyspnea or orthopnea is or is not present on examination, evidence of increased venous pressure, the presence or absence of pulmonary rales (including the type, relative number, and location), the heart size as determined by percussion and palpation, the presence of murmurs or friction rubs, the quality and character of heart sounds, the presence of hepatomegaly, and the presence, location, and degree of peripheral edema.

In reporting pertinent laboratory data the numerical results of tests should accompany the conclusions drawn from them. In reporting a chest x-ray the actual reading, including the description of the heart size and contour, changes in the prominence of the bronchovascular markings, the presence or absence of pleural effusion and similar details forcefully document the conclusion that the chest x-ray shows "congestive failure" or "cardiomegaly." Similarly, the description of the abnormalities noted in the electrocardiogram, including the presence or absence of significant Q waves, ST segment alterations, and T-wave changes in the various leads, and whether there are significant changes in serial elec-

trocardiograms, permits a reviewing physician to assess the conclusion that the "electrocardiogram shows an acute myocardial infarction."

Since many cardiovascular or respiratory diseases can be significantly improved with appropriate therapy and may permit continued employment for significant periods of time, an adequate medical report should clearly state the medications and other therapeutic measures employed, including dosages and response to treatment. Lastly, the reporting physician's own estimate of the applicant's ability to perform those physical functions which are necessary for employment; i.e., sitting, standing, walking, climbing, lifting, carrying, bending, and the like, is greatly appreciated. Obviously if all of this information is present in a claim file, adjudication of that claim is more accurate.

Orthopedic and Neurological Impairments. Orthopedic and neurological conditions tend to restrict an applicant's functional ability by producing pain, loss of motion in joints, loss of strength and paralysis in extremities, or loss of sensation and coordination. Careful description of these abnormalities, both historically and on physical examination, provides the reviewing physician in the State Agency with a realistic and clear picture of the applicant's condition and his remaining functional capacities. The range of motion in arthritic joints can easily be expressed in numerical figures; atrophy of muscles resulting from orthopedic and neurological conditions can be measured; and strength of various members can be estimated fairly accurately by experienced physicians. X-ray abnormalities can be described in the manner previously suggested for chest x-rays. Electromyographic and electroencephalographic reports can similarly be detailed.

Emotional Illness. It is often difficult to communicate in writing a clear description of emotional illness, how it restricts an applicant's ability to engage in gainful activity, and what remaining capacities exist. However, an attempt should be made to describe the applicant's complaints in detail, including verbatim reports of his remarks, a description of his appearance, whether he is able to come to the office unaccompanied, and other first-hand observations.

It is reasonable to expect that a significant loss of capacity would reflect itself, not only in ceasing work but also in regressive personal and social patterns. Therefore, a report of an emotional illness which describes how the applicant's tension or anxiety state restricts personal and social activities is valuable for disability evaluation.

Objective evidence of any mental regression, loss of interest in personal appearance and usual activities, impaired capacity for concentration, abnormalities of appetite and sleep cycle, evidence of agitation, preoccupation with suicidal ideas and actual attempts at suicide can be provided by specific examples. In applicants with organic brain syndrome specific evidence of intellectual or emotional regression should be reported. Specific examples relative to loss of memory for recent events or erroneous responses to questions are helpful in assessing the severity of the condition.

Reports on retarded children should follow the same pattern. For example, a severely retarded child may require supervision and assistance in dressing and feeding himself and avoiding common dangers. He may also be unable to learn or make progress in school, have a bizarre appearance or mannerisms, or peculiar behavior, or overt evidence of lack of normal judgment in ordinary activities.

If psychometric tests have been obtained, the raw scores of the sub-tests as well as the total I.Q., in addition to the psychologist's observations and evaluation, provide objective evidence of the severity of mental retardation. Projective psychological testing helps to clarify the nature and severity of emotional illness when a detailed report of this information is included.

METHOD OF REPORTING MEDICAL INFORMATION

In recent years the Social Security Administration employed a structured form for reporting medical information. This form is familiar to most physicians in Wisconsin. Because of the structured nature and the lack of space for recording information, it stimulated brief, one-sentence responses that tended to be conclusions rather than the precise facts upon which the conclusions were based. These deficiencies led to the decision to initiate a new reporting form that contains adequate space for detailed descriptions of the medical findings. The reporting physician will be asked to report in narrative form the history of the present illness, present symptomatology, a detailed report of pertinent physical findings, results of laboratory and x-ray tests, diagnosis, and prognosis. A summary is requested of the therapeutic measures which have been taken and the physician's evaluation of the applicant's remaining functional capacities.

It should be noted that photocopies or carbon copies of existing letters, reports, and/or medical summaries may adequately provide the information needed and obviate the necessity of completing the form. Such reports are perfectly acceptable to the Disability Determination Unit. If the reporting physician prefers to provide his report in any other manner, it will be equally acceptable, so long as the information provided meets the evidentiary needs described previously.

By law, the applicant is responsible for furnishing medical information to document and support his claim and for assuming any expense involved in obtaining this information. For this reason it is not possible for the Social Security Administration to pay the reporting physician a fee for these reports. The applicants are informed by the representatives of the Social Security Administration of their financial responsibility in obtaining this evidence.

If we continue to exchange information on the evidence needed to determine disability and the

methods most convenient for physicians to provide medical information, I am sure we will achieve fair and accurate decisions, reached promptly and economically with a minimum need to recontact the reporting physicians for further information. I believe that the physicians in the State of Wisconsin will agree that these are all worthwhile aims.

117½ Monona Avenue (53703).

For Your Information from the

Wisconsin State Board of Health

MORE AGED REQUIRE MORE CARE

THE PAST FEW years have seen nursing homes and homes for the aged increase at a rapid rate in our state. It is the intention of this report to trace the recent growth of these facilities and perhaps provide some insight into the future needs and capabilities.

In Wisconsin, both private and public homes are operated under standards of maintenance and operation set by either the State Board of Health, or the State Department of Public Welfare. Those under the former agency will be referred to as "licensed homes" and those under the latter as "county homes." All homes must also meet requirements of the State Building Code of the Industrial Commission of Wisconsin.

The validity of the following observations is dependent upon two assumptions: first, that occupancy rates reflect the demand for these facilities, and second, that the mobility status of residents is related to the type and the amount of care they need.

Table 1 summarizes the increase that has occurred in the number of beds available in both county homes and licensed homes since 1956, as well as the average daily census and the rate of occupancy. The number of beds in licensed homes increased from 8,956 in 1952, when licensing first became mandatory in Wisconsin, to 15,686 in 1962; an average increase of 673 beds each year. The rate of increase was lowest at the beginning of the period, averaging only about 460 beds per year from 1952 to 1956. Since then, beds have become available at a much greater rate, with an average annual increase of over 800 beds per year since 1956.

Part of the increase in beds in the licensed homes is a "paper increase." Some boarding homes for elderly persons eventually come under the licensing requirement as the permanent residents increase in age and begin to require care. This factor increases the number of beds licensed although it is not an actual increase in the number of beds available as they are already occupied. An exact evaluation of the proportion of the annual increase because of this factor cannot be made, but a subjective estimate puts it at about 30 per cent of the total.

Beds in county homes have also increased. In 1956, there were 3,652 beds in county homes; by 1962 the number increased to 5,834, an average increase of 360 beds per year. The increase in county home beds has resulted from new construction and from the conversion of tuberculosis sanatorium and mental hospital beds. Approximately 1,000 beds have been converted since 1952, and the balance has resulted from new construction.

Table 1 shows a total of 14,440 beds for both county and licensed homes in 1956. By 1962, the total had increased to 21,520 beds. This is an increase of about 50 per cent over the period. This high rate of increase might lead one to wonder if the need for these facilities has not been met or even surpassed. The number of persons 65 years old or over in the total population has only increased by about 30 per cent in the ten-year period from 1950 to 1960. This age group makes up about 90 per cent of the resident population of nursing homes. Thus the available facilities have shown a much greater proportional increase and in a shorter period, than has the part of our state's population that is the greatest user of these facilities.

The fourth and fifth columns of Table 1 show the average daily census of county and licensed homes. The last column of the table gives the occupancy rate for total beds for each year. Some licensed homes are known to be operating with less beds than they are legally allowed. Therefore, the occupancy rate as given here is a minimum because the number of beds for each year is the total number legally allowed. The most important fact shown by this table is that the occupancy rate has remained constant, or possibly increased slightly in spite of the rapid increase in beds available. It seems unlikely that the occupancy rate would remain constant if the increase in facilities had outrun the demand.

The demand for these facilities is not necessarily a reflection of the need for them. In other words, the increased number of beds might be filled by persons requiring them only for domicile. Some insight into the characteristics of persons using the facilities of these homes may be obtained from reports routinely required of each home. One of the most significant facts reported is the mobility status of each resident.

Each licensed home reports the mobility class of each resident of the home at the close of the calendar year, and again at midyear when licenses are renewed. Similar information is collected from the county homes and is reported annually by the State Department of Public Welfare. There are minor differences in the terminology used by the Board of Health and by the Welfare Department but the definitions are similar. Both county homes and licensed homes report their residents according to three levels of mobility: "ambulatory, capable of self-care," "semi-ambulatory, needing care," and "bedridden or chairfast." Figure 1 shows the trend of the proportion of total residents of both county and licensed homes in the two classifications that require the most care, semi-ambulatory and bedridden. This proportion has increased slowly but steadily over the period. In 1952, 38 per cent were

continued on page 392

THE PRESIDENT'S PAGE . . .

W. P. CURRAN, M.D.
Antigo, Wisconsin

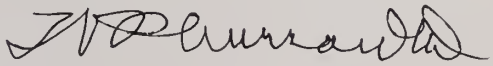
WE CAN HELP!

The Traffic Injury Problem

■ ONE IS APPALLED by the continuation of the slaughter of human beings on the highways and county roads of the State of Wisconsin. At this writing, the count of the dead as a result of automobile accidents is over 100 ahead of the number killed a year ago.

It becomes apparent that law enforcement alone is not the answer to this problem, and other means will have to be utilized by all of us to try and halt this needless waste of human life and talent. When one considers that the number of people who are injured as a result of these accidents, rises to staggering proportions, along with the pain and suffering during their convalescence, and the deformities that are tied in with this type of injury, it should behoove us, as physicians, to take another look at what can be done to make the highways of the state a better place in which to live.

Our State committees have done a great deal of work on problems dealing with traffic accidents, and the results of their work can be made available to any interested groups. I believe that all county medical societies should make an extra effort to cooperate with any local groups in trying to solve their local traffic injury problem. If no local group exists for this purpose in some communities, there is no better informed group than the local physicians to form a steering committee around which can be built an effective program of education to people in the community, in the schools, and in the home.



the WISCONSIN MEDICAL JOURNAL
Published Monthly
SEPTEMBER 1964
Vol. 63 No. 9

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

For the Battered Baby

■ THE NEXT SESSION of the General Assembly of the State of Illinois will consider a bill requiring Illinois doctors and hospitals to report cases of abused children to a social welfare agency. If the legislation is passed, doctors acting under its provisions would be immune to lawsuits brought by the parents of the children reported.

The proposed Illinois law provides that when a doctor suspects a child has been abused, he must report the matter to the state's department of children and family services. This agency investigates and attempts to prevent recurrence of the abuse. If it continues, however, the agency would then report the parents to the proper law enforcement authorities. The agency also would have the right under the proposed law to determine if *other* children in the home were being abused following the initial report by a doctor.

The recently enacted Wisconsin statute, published September 27, 1963, merely permits a doctor to disclose information acquired in a professional capacity where there is reasonable ground for an opinion that the abused minor received his injuries by intent of another person. It directs that the report be made to the district attorney or sheriff of the county.

The Illinois bill is modeled after a prototype statute drafted by the children's bureau of the United States Department of Health, Education and Welfare. It is supported by the AMA, and it is expected to receive the support of the Illinois Medical Society and the Illinois branch of the American Academy of Pediatrics when it comes before the legislature next January. Over 30 social welfare, medical, and civic agencies in Illinois were consulted in preparation of the bill, and it is anticipated that no serious opposition will be offered to its passage.

It is encouraging that positive action is being taken in a neighboring state to come to grips with the increasing number of battered children that doctors see. While it is true that Illinois, with its larger population and relatively larger numbers of economically depressed families, probably has a greater number of cases of abused children, it is also true that the syndrome is not confined to any socio-economic group and it is not unknown in Wisconsin.

It is also encouraging to learn that a formula has been

found that interposes a social agency between doctors and the police, thereby switching the emphasis on reporting abused children from punishment to correction. The proposed Illinois statute is designed primarily to protect the children, and utilizes the techniques of persuasion, recommendation, and family counselling before resorting to arrest and trial. Thus, with immunity from legal involvement, the doctor can be free to report incidents of abuse secure in the knowledge that he has acted in good conscience on behalf of the child, and will most likely have instituted both corrective and prophylactic measures as well.

Similar legislation to permit prompt action in cases of child abuse is urgently needed in our state. The moral duty to protect children cannot be ignored, and Wisconsin should not be laggard in facing its responsibility in an unpleasant and touchy problem.—D.N.G.

The AMA in Tobacco Research

EDITOR'S NOTE: The medical profession sustained severe criticism following acceptance by the AMA of a large sum of money from the tobacco industry for the study of the link between tobacco and cancer. When a representative of the AMA testified before a Senate subcommittee in behalf of the tobacco industry's stand on labelling, many persons saw proof of the sell-out of the doctors to the big money cigarette manufacturers.

The following editorial, which appeared in the GREEN BAY PRESS–GAZETTE *of June 14, 1964 is a thoughtful, well-stated explanation of the role of medical science vis-a-vis the tobacco industry. It is worth careful reading and wide dissemination, especially to the doctor baiters who enjoyed a field day of finger-pointing and eyebrow-lifting.*

* * *

The American Medical Association through its Education and Research Foundation has launched its first studies under a long-range research program on tobacco and health which was authorized by the AMA House of Delegates last December.

Ten grants for study have been authorized. Twenty-seven applications for grants have been received and about 25 more are in preparation.

Under the grants approved so far, scientists will study the action of nicotine on cells, seek to produce synthetic radioactive nicotine for research, find more facts on the relationship between cigarette smoking and cardio-pulmonary disease, to study the effects of nicotine on the human heart, to determine how cigarette smoke affects the ability of the lungs to clear foreign particles, to measure the addictive qualities of nicotine, to study the effects of nicotine on heart muscle cells, and to study nicotine as a stimulant or a tranquilizer.

The first-year grants will cost approximately $340,000. The duration of the projects will range from two to five years. It is agreed that the approval of a project is a moral commitment to support the project for the full period for which it was approved, subject to annual evaluation of progress. If all 10 projects are carried through for their designated duration, the total financial outlay will approximate $800,000.

The AMA Foundation's tobacco and health research program is financed from a $10 million, five-year unrestricted grant from the six major tobacco companies.

When the arrangement between AMA and the tobacco companies was first announced it caused considerable comment and some lifting of the eyebrows. Many people thought that the scientific report put out by the federal government condemning cigarette smoking as a cause of cancer would immediately result in a great change in the smoking habits of the public. The members of the Medical Association have been among those condemning the cigarette as a cause of cancer and at first glance many people thought that the doctors should devote their time and attention to banishing the cigarette from our lives completely. The idea of the Medical Association in joining the tobacco companies in an effort to minimize or eliminate the portions of the cigarette which caused cancer seemed somehow inconsistent. But it must be quite apparent now that this is not the case. People are smoking in spite of the warnings from the government. Many people will continue to smoke, and new smokers join their ranks every day. The efforts to have people discontinue smoking in groups has apparently

failed. Many individuals, it is true, have given up smoking but that apparently is not to be trusted as a means of eliminating cancer caused by smoking.

The Medical Association is obviously on the right track. The greatest help to people, including smokers, is to discover what there is about the cigarette which causes cancer and to eliminate that or protect the smoker against it. That is obviously the goal of the researchers and it will be well worth $10 million to bring it about.

MORE AGED REQUIRE MORE CARE

continued from page 388

in the two groups requiring the most care and by 1962 this percentage increased to 48. It does not seem likely that this proportion would increase if an oversupply of beds existed, particularly since the occupancy rate has not decreased. It appears that the demand measured by occupancy rate, and the need for care as measured by mobility status, have not yet been met by the increase in the facilities available.

There has also been an increase in the proportion of persons in the older age groups in county homes as shown in Table 2. In 1950, persons 65 years of age and over made up 67.6 per cent of the resident population of county homes. This percentage increased to 77.2 in 1956, and had reached 85.2 by 1962. Exactly comparable information on the ages of persons in licensed homes is not available. However, a study carried out in 1955 showed 87 per cent of the residents at that time were 65 years of age or over. Additional information gathered in 1962 shows that approximately 93 per cent of residents of licensed homes were 65 years of age or over. Thus the age of residents of licensed homes is also increasing. This factor may in part account for the increased numbers requiring care.

In summary then, it is observed that nursing home facilities in Wisconsin have increased by about 50 per cent from 1956 to 1962. In spite of this increase, the occupancy rate has remained constant and the proportion of residents requiring the most care has increased. The proportion of residents in the 65-and-over age group has also increased. The demand for facilities appears to be increasing at least as rapidly as they are being supplied at present.—C. W. LEMKE, M.S., *Statistician in the Division of Statistical Services*, Bureau of Vital Statistics, Wisconsin State Board of Health, Madison.

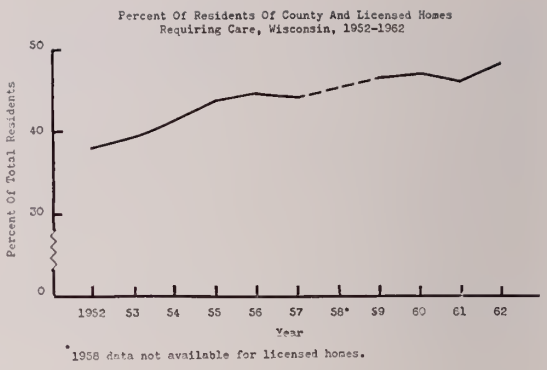

Figure 1

TABLE 2—*Trend in Age Distribution of Residents of County Homes in Wisconsin*

Age	1950	1956	1962
Total Number of Residents of all Ages	2,899	3,543	5,749
Percentage Distribution by Age:			
All Ages	100.0	100.0	100.0
Under 65 years	32.4	22.8	14.8
65 to 74 years	30.1	26.7	20.8
75 to 84 years	28.1	33.8	40.4
85 and over	9.4	16.7	24.0

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1. Characteristics of residents of county and city homes in Wisconsin. State Department of Public Welfare, Bureau of Research, Statistical Bulletins PA-1 and PA-4.
2. Trends in characteristics of residents of county and licensed homes. Unnumbered mimeographed report, Statistical Services Division, Bureau of Vital Statistics, Wisconsin State Board of Health, June, 1963.
3. Wisconsin state plan for hospital and medical facilities. Various issues. Division of Hospitals and Related Services, Wisconsin State Board of Health.
4. Unpublished Report. 1955 Survey by Hospitals and Related Services Division, Wisconsin State Board of Health files.
5. Directory of homes for the aged and nursing homes licensed in Wisconsin, 1956 through 1962. Hospitals and Related Services Division, Wisconsin State Board of Health.

TABLE 1—*Rate of Occupancy of County Homes and Licensed Homes in Wisconsin*

Year	Number of Beds			Average Daily Census			Total % Occupied
	County	Licensed	Total	County	Licensed	Total	
1956	3,652	10,788	14,440	3,056	8,731	11,787	81.6
1957	3,808	11,671	15,479	3,307	9,546	12,853	83.0
1958	4,422	12,438	16,860	3,647	9,806	13,453	79.8
1959	4,466	13,112	17,578	4,124	9,823	13,947	79.3
1960	5,019	12,890*	17,909	4,291	10,704	14,959	83.5
1961	5,163	14,500	19,663	4,836	11,316	16,152	82.1
1962	5,834	15,686	21,520	5,642	12,858	18,500	85.9

*A 460-bed institution was reclassified and excluded in 1960, accounting for the decrease in the number of beds from 1959 to 1960.

REPORTS AND TRANSACTIONS OF 1964 ANNUAL SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin
MAY 10-12, 1964

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REPORTS PRESENTED TO THE HOUSE OF DELEGATES AT THE ANNUAL SESSION

State Medical Society of Wisconsin May 10–12, 1964

The Annual Session of the House of Delegates of the State Medical Society of Wisconsin was held at the Hotel Schroeder and Milwaukee Auditorium in Milwaukee, Wisconsin, May 10–12, 1964.

Presented below are reports submitted to the House. Following these reports is the Transactions of the House which includes the recommendations of the reference committees and the House actions on these reports.

■ REPORT OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

T. W. Tormey, Jr., M.D., Madison, Chairman
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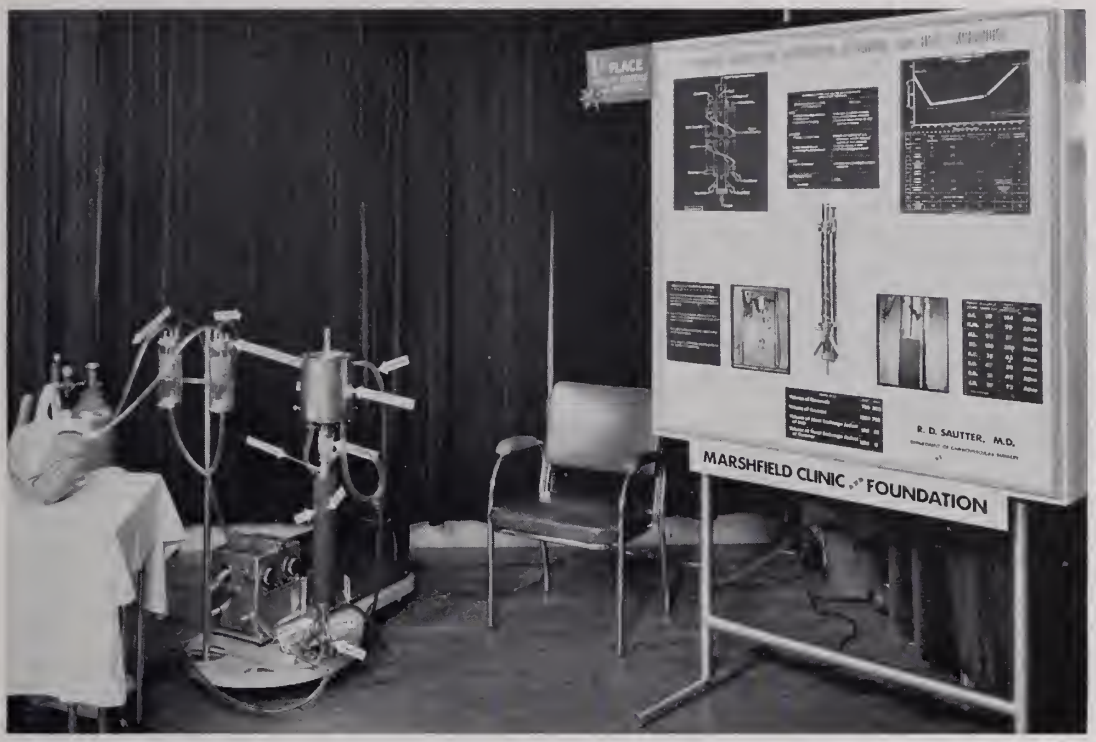
H. W. Carey, M.D., Lancaster
R. B. Windsor, M.D., Sheboygan
M. S. Fox, M.D., Milwaukee

The report of the Commission on State Departments is necessarily composed, for the most part, of the reports of the several Divisions which comprise the Commission and carry out the functions and activities within each one's particular area of concern. The Commission wishes to emphasize the amount of work carried out by the Divisions in representing the interests of the State Medical Society. Among the recommendations of the Divisions approved by the Commission are the following:

1. The Division on Rehabilitation recommends that the State Medical Society negotiate a revised schedule of fees with the State Board of Vocational and Adult Education, to replace the schedule agreed to in 1959. The State Board's Division for Vocational Rehabilitation has asked that the schedule be upgraded to provide a more reasonable fee, particularly in the area of consultative examinations for applicants for disability benefits under OASDI.
2. The Division on Visual and Hearing Defects has considered the matter of additional eye banks outside Milwaukee County and recommends that such expansion be done with due deliberation, and that no further eye bank facilities be set up in Wisconsin until the Milwaukee Eye Bank is functioning at full capacity.
3. The Division on Visual and Hearing Defects recommends that a positive program be developed toward the ultimate goal of curbing abuse of the title "Doctor."
4. The Division on Nervous and Mental Diseases recommends strong support by the Society for Bill 170, S., which would change the state reimbursement to county mental hospitals in such a manner as to encourage counties to develop local care, and prevent counties from profiting from state average reimbursements by keeping county hospital care inferior and cheap.
5. The Division on Nervous and Mental Diseases recommends that legislation be re-introduced to permit payment of medical care to public assistance recipients who are in a general hospital primarily because of a diagnosis of psychosis.
6. The Division on Nervous and Mental Diseases recommends Society support of the Interstate Mental Health Compact in the most recent version in which it appeared in Bill 167, S., since it no longer violated the rights of the individual patient or his family. Bill 167, S., was defeated in the current legislative session.
7. The Division on Nervous and Mental Diseases recommends a proposed bill to amend the Motor Vehicle Licensing Laws to eliminate the present question pertaining to legally adjudged insane, and to require instead that each hospital superintendent to report to the Motor Vehicle Department the name of any committed patient who has left the institution and who is, in his opinion, possibly unsafe to drive.
8. Pursuant to a request by the House of Delegates in May, 1963, the Division on Nervous and Mental Diseases has reviewed the function and operation of Community Mental Health Clinics and formulated a statement on this subject.
9. The Division on Aging recommends a statement of principle that routine physical examinations are of significant value to persons of all ages and particularly persons in advancing years when early detection and diagnosis of disease becomes of increasing importance, and that such examinations be performed at a professional charge commensurate with the patient's ability to pay.
10. The Division on Aging recommends the expansion and development of ancillary health services on a community level, where needed, including such services as visiting housekeepers, visiting nurses, therapists and, when necessary, meals on wheels.
11. The Division on School Health recommends that the Society's publication "School Health Examinations" not be reprinted and that the State Board of Health and State Department of Public Instruction, with representatives of the medical and dental professions, publish a booklet for educators and that such information be published in the *Wisconsin Medical Journal.*
12. The Division on School Health recommends that the problem of increasing demands on student health services due to rapidly increasing college enrollments be placed before the Board of Regents of State Colleges and the appropriate bodies of private colleges in the state, with an offer of Society assistance in establishing standards for college health services in Wisconsin.
13. The Division on School Health recommends that oxygen be used only for medical purposes under the direction of the team physician when used by athletes during athletic competition.
14. The Division on Maternal and Child Welfare has been concerned with problems arising in the area of duties delegated to nurses and notes that in many situations nurses give injections, perform blood transfusions and do many other procedures which heretofore have been regarded as being strictly responsibilities of the physician. The Division notes that even though such procedures may be performed under the direction of the physician, probably making him responsible, this does not satisfy the question as to whether expanded nurse



SCIENTIFIC EXHIBIT: FIRST PLACE—Smaller Hospitals and Individuals. "Compact Single Unit Oxygenator, Heat Exchanger and Reservoir for Hypothermic Hemodilution in Total Body Perfusion" by R. D. Sautter, M.D., Marshfield Clinic & Foundation, Marshfield.

activities are good or bad in terms of patient care. Since this subject is of wide policy determination beyond the scope of obstetrical care alone, the Division recommends that the Council initiate a study of this subject on a broad base of nurse-physician relationships and that the Division be represented in such a study.

Among other matters before the Commission during the past year was the subject of gamma globulin and the economics of maintaining a supply by individual physicians to be replaced by the State Board of Health after it has been administered. The Commission referred this matter to the Division on Maternal and Child Welfare which prepared an article for the *Wisconsin Medical Journal*, page 90, January 1964, issue, on the subject of attenuated measle vaccine and recommends a statewide program for immunization of individuals susceptible to the disease, conducted through active promotion in the office of each physician. The Division hopes that emphasis on immunization will greatly reduce the emphasis on gamma globulin, and the Commission has agreed to review the problem again in about a year to see the results.

The Commission recommends the adoption of the Principles for Transporting the Ill and Injured prepared by the Division on Safe Transportation with the requirements relating to visual and hearing standards as clarified by the Division on Visual and Hearing Defects. These standards will be made available to all persons interested in emergency transportation of ill or injured persons. Model ordinances would be available in limited quantities on request, for adoption by municipalities concerned with the problem.

For the benefit of the Divisions which are concerned with the diverse multitude of problems coming before them and the Council which must necessarily rule on policy matters between sessions of the House, the Commission recommends that the Chairman of the appropriate Division be asked to attend the Council meeting subsequent to one at which a question is raised opposing that Division's recommendation and that the Council defer action until the Division Chairman has an opportunity to be heard. This follows closely a recommendation of the Reference Committee on Reports of Officers at the May, 1963, meeting of the House of Delegates that the Chairman of Divisions, or his designee, appear before the appropriate reference committee so that the Society as a whole might obtain a greater understanding of their programs.

■ REPORT OF DIVISION ON AGING OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

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Patricia F. Lanier, M.D., Kewaunee
S. E. Siverstan, M.D., La Crosse
W. C. Kleinpell, M.D., Kenosha

Two recent publications will be reviewed and considered with great interest by the Division during the coming year. One of these is the Proposed Revision of Rules for the Construction, Maintenance and Operation of Nursing Homes and Homes for the

Aged Licensed by the State Board of Health. This very important project was conducted by an Advisory Committee on Nursing Home Standards appointed by the State Board of Health and contained representatives of medicine, public health, public welfare, hospital administration, nursing home operation, civic interests, social services and professional nursing. Among other things, the new rules would establish three categories of nursing homes:

(1) Home for Skilled Nursing Care, which is a home staffed, maintained and equipped for the accommodation of individuals who are not acutely ill and not in need of hospital care, but who require skilled nursing care;

(2) Home for Limited Nursing Care, which is a home staffed, maintained and equipped for the accommodation of individuals who are not acutely ill and are not in need of hospital care or skilled nursing care, but are in need of limited care; and

(3) Home for Personal Care, which is a home staffed, maintained and equipped for the accommodation of individuals who are not acutely ill and are not in need of hospital care, skilled nursing care or limited nursing care, but require personal care.

The rules go on to define skilled nursing care, limited nursing care and personal care. The proposed new rules were first received on February 6, 1964, and additional study is felt necessary. It should be noted that public hearings were to be held on the rules on March 23, in Milwaukee; March 24, in Green Bay; and March 25, in Eau Claire. Interested physicians were strongly urged to review the new rules and to attend the hearings to voice any objections or suggestions.

The second document, which the Division has requested copies of from the AMA, are the Standards for Accreditation adopted by the National Council for the Accreditation of Nursing Homes. It is understood that the AMA participated in the establishment of these Standards and the Division is hopeful that they will prove to be useful in establishing uniformly higher quality of nursing homes throughout the State. The enactment of a Kerr-Mills enabling act in Wisconsin, the Health Assistance Payments Act of 1963, in combination with the trend toward more extensive use of such facilities, places an added emphasis on the need for uniform standards and high quality of care and facilities.

The Division considered two requests by the State Commission on Aging during the past year. One proposal was to the effect that the State Medical Society establish a program to make physical examinations at a reduced fee available to persons 65 years of age and over. After thorough consideration the Division recommends rejection of this proposal. The Division recommends, instead, adoption of a statement of principle that routine physical examinations are of significant value to persons of all ages and particularly persons in advancing years when early detection and diagnosis of disease becomes of increasing importance, and that such examinations be performed at a professional charge commensurate with the patient's ability to pay. The Division recognizes that physicians annually give much free time to the treatment of elderly patients without charge, there are many other elderly patients well able to afford professional fees for care and the establishment of fees lies solely in the discretion of the individual physician.

The second recommendation by the Commission on Aging related to the development of ancillary health services on a community level. The Division views with favor this expansion of services where needed, and recommends the following:

> Local medical societies should cooperate in the development and implementation of services ancillary to the physician's care of older patients who are chronically ill to enable them to return home at an earlier date. Such services might include visiting housekeeper, visiting nurses, physician home calls, therapists, and when necessary, meals on wheels. It is recognized that early return home can often mean lower health care costs as well as improved patient morale, although care should be taken to prevent undue isolation of the patient in his or her home to the detriment of the person's health or well being.

The Division has prepared an article for the *Wisconsin Medical Journal* on the "Medical Aspects of Nursing Home Operation." It has given consideration to a suggestion that the State Employment Service be asked to establish special facilities to assist persons over 65 to find full or part-time employment. Further information is being requested before taking final action on this proposal.

■ REPORT OF DIVISION ON HANDICAPPED CHILDREN OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

J. W. Nellen, M.D., Green Bay, Chairman
F. D. Bernard, M.D., Madison
John J. Suits, M.D., Marshfield
George H. Handy, M.D., Wisconsin Rapids
James E. Miller, M.D., Madison
Lloyd P. Williams, M.D., Appleton
Robin Allin, M.D., Madison
Donald A. Jeffries, M.D., Shawano

The Division on Handicapped Children is essentially advisory to the Bureau of Handicapped Children of the Department of Public Instruction. Since its report to the House in October, 1963, the Division has not formally met but it has kept in touch with the medical advisor to the Bureau of Handicapped Children and it is anticipated that within the next six months a meeting of the Division will be held.

Primarily, the Division has been concerned with the Orthopedic Clinics conducted by the Bureau. As situations have changed, and more private orthopedic services have been available in regional areas of the state, there has been a request in certain communities that the orthopedic clinics be discontinued. When such action has been taken by the County Medical Society the Bureau has acceded to the wishes of the County Society. This past year in Sheboygan County the clinics which had been discontinued are being reinstated at the request of the County Society.

As reported to the House in October, 1963, the Bicillin program initiated by the Bureau has been transferred to the State Board of Health so that its services could be extended to individuals over 21 years of age.

A pilot study of the support of children suffering from cystic fibrosis is being conducted, as approved by the Division, and will be reported to the House at a later date.

At the present time the Bureau of Handicapped Children is making a study of Chapter 142 of the Wisconsin Statutes relating to the University Hospitals and its relationship with services of the Bureau. Changes which will be of concern to the medical profession will be reported at a later date.

■ REPORT OF DIVISION ON MATERNAL AND CHILD WELFARE OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

John R. Evrard, M.D., Milwaukee, Chairman
Richard C. Brown, M.D., Eau Claire
William R. Kreul, M.D., Racine
T. A. Leonard, M.D., Madison

B. P. Waldkirch, M.D., De Pere
E. A. Birge, M.D., Milwaukee
Stewart L. Griggs, M.D., Green Bay
K. J. Winters, M.D., Wauwatosa
F. G. Johnson, M.D., Superior
George H. Stevens, M.D., Wausau
J. D. Wilkinson, M.D., Oconomowoc
Lloyd J. Steffan, M.D., Plymouth

Since last reporting to the House several projects worthy of comment have been completed while other matters are being studied and will be reported on at a later date.

OB Nurse Training Program

As an outgrowth of the Maternal Mortality Survey a pilot program of special nurse training in obstetrics was conducted at St. Joseph's Hospital last fall. The purpose of the program was to provide intensive "on-job" training for a limited number of nurses from smaller hospitals so that they in turn could be of greater service to the physicians in their home communities. The success of this program has resulted in a continuation of the training now being provided under the joint auspices of St. Joseph's Hospital, Marquette University and the Wisconsin State Board of Health. It is hoped that during the ensuing years most of the smaller hospitals in the state can be served by this specialized nurse training project.

Fibrinogen Survey

Another matter related to the Maternal Mortality Survey has been the apparent need to have physicians and hospitals aware of available supplementary sources of fibrinogen if unusual bleeding in the care of an obstetrical patient exhausts the available supply in the hospital or the community. The Division, in cooperation with the Bureau of Maternal and Child Health of the State Board of Health, has made a survey of fibrinogen supplies in all Wisconsin hospitals, and has sent to all hospitals a listing of available sources. In areas where supplies are inadequate for anticipated needs the State Board of Health is prepared to stockpile additional amounts of fibrinogen to meet emergency needs.

Educational Programs

Because the American Academy of Obstetrics and Gynecology and the Wisconsin Academy of General Practice had announced plans for a series of jointly sponsored teaching programs on "The Difficult OB," no meetings related to the Maternal Mortality Survey have been scheduled by the Division since last reporting to the House. Inasmuch as the anticipated programs have not materialized it is hoped that in the next academic year the interpretive programs related to the Maternal Mortality Survey can again be resumed. Their reception, when held, indicated that these practical teaching programs are of value to physicians and hospital personnel alike.

This past month a series of teaching programs on the "Care of the Newborn" have been conducted in La Crosse, Manitowoc, Janesville and Beaver Dam. These will be augmented by three additional programs in New Richmond, Superior and Antigo in June. The programs are aimed at both nurses and physicians and cover the subject of prematurity as well as special problems of the full term newborn.

A third educational effort of the Division, conducted cooperatively with the Wisconsin Society of Obstetrics and Gynecology and the Wisconsin Society of Anesthesiology, is related to the Annual Meeting. This is a series of demonstrations on "Transvaginal Pudendal Nerve Block" which are provided during the scientific sessions at the Milwaukee Auditorium on May 11–12–13. It is hoped that many physicians will take advantage of these demonstrations to improve their obstetrical knowledge and skills.

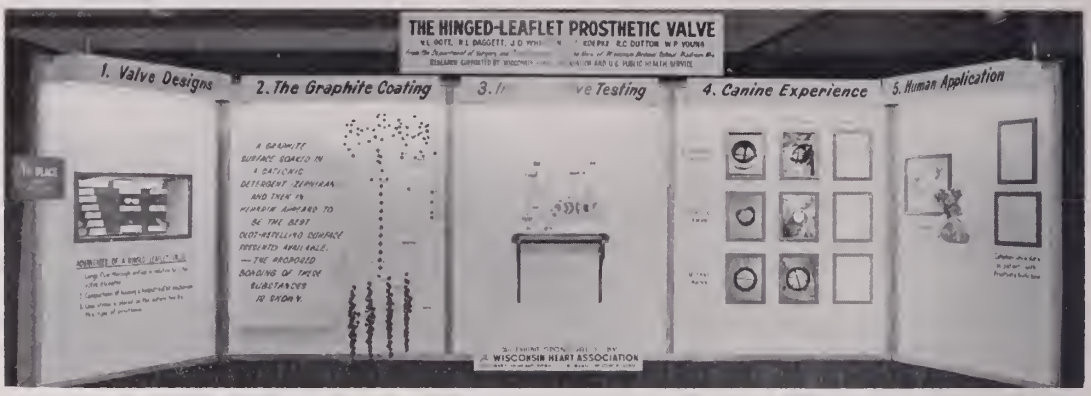
Adoption Procedures

Working cooperatively with the Division of Children and Youth of the Department of Public Welfare, the Division on Maternal and Child Welfare has helped develop procedures and reporting forms which it is hoped will improve medical evaluations required for adoption applications through the state agency. At the same time the Division has encouraged the Division of Children and Youth to utilize medical consultants in areas of obstetrics and pediatrics to assist the regional offices in processing applications and reports which involve medical opinion or diagnostic information.

Pending Projects

The Division is aware of the fact that many hospitals have requested a "new look" at current regulations as to restrictive use of beds which are set aside for care of obstetrical patients. This is a national problem, and one which has to be studied carefully in relation to hospital accreditation, and policies established on the national level through the AMA. At present there seems little likelihood that current regulations can be changed, as indications are that any modification of current rules would seriously endanger the hospital's accreditation. The matter is being studied by the Division, and when the time appears appropriate to make specific recommendations as to modifications, this will be done after careful study with the State Board of Health and the Wisconsin Hospital Association.

Another matter of continuing concern to the Division is the frequent request on the part of physicians, particularly those practicing in smaller communities, that the Division relax its recommendations on such matters as nurse administration of pitocin, the nurse use of trilene and the nurse conducting vaginal examinations without the direct supervision of the physician. The Division is aware of certain problems which arise in communities with limited physician and nursing service, but the Division does feel that standards of practice cannot be sacrificed as a matter of individual convenience. The Division has made specific recommendations *(not rules*, as the Division has no such authority) on the subjects mentioned, and hospital staffs are requested to consider these recommendations as a base-line for proper hospital staff regulations which will give maximum protection to the obstetrical patient being served. The Division is aware, however, that there are many physicians who feel the current philosophy of keeping the nurse "out of the practice of medicine" is possibly outmoded in many areas. Division members are aware of the fact that in many situations nurses give injections, perform blood transfusions and do many other procedures which heretofore have been regarded as being strictly responsibilities of the physician. Even though performed under the direction of the physician, probably making the physician legally responsible, this does not satisfy the question as to whether expanded nurse activities are good or bad in terms of patient care. In situations where an adverse reaction to a performed nurse procedure might occur it has generally been accepted that care of the patient is beyond the scope and training of the nurse. If such is no longer the case it is a subject of wide policy determination beyond the scope of obstetrical care alone. It is hoped and recommended by the Division that the Council initiate a study of this subject on a broad base of nurse-M.D. relationships, and that in such a study the Division be represented.



SCIENTIFIC EXHIBIT: FIRST PLACE—Large Hospitals. "The Hinged-Leaflet Prosthetic Heart Valve" by Drs. V. L. Gott, J. D. Whiffen, D. E. Koepke and W. P. Young; R. L. Daggett, M.A.M.E.; R. C. Dutton, B.S.; Department of Surgery and Cardiovascular Laboratory, University of Wisconsin Medical School, Madison, and the Wisconsin Heart Association.

In closing this report to the House the Chairman wishes to emphasize the fine cooperation extended to the Division in its many efforts. This is particularly so in relation to the Maternal Mortality Survey. As it has been conducted since 1953 this remains as educational, and not an investigative project, and it is being accepted as such by the profession. The finest cooperation has been extended to the Committee and the interviewers by those attending physicians who have had the misfortune to experience a maternal death in their practice. The warm reception of the various teaching programs and published items which have been an outgrowth of this Survey give further testimony to the soundness of the project and its contribution to the medical knowledge of Society members.

Much of the work of this Division revolves around efforts of the Bureau of Maternal and Child Health of the State Board of Health, and this report would be incomplete without an expression of appreciation for the cooperation and support accorded the various programs of the Division by Dr. James Wardlaw and his staff.

Obviously, all of the problems in relation to work of this Division have not been solved, but the Division is pleased to report certain accomplishments which it is hoped will be of value to the profession and the obstetrical patients and parents being served by members of the State Medical Society.

■ REPORT OF DIVISION ON NERVOUS AND MENTAL DISEASES OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

Charles A. Wunsch, M.D., Green Bay, Chairman
Jean P. Davis, M.D., Milwaukee
A. A. Lorenz, M.D., Eau Claire
T. J. Nereim, M.D., Madison
K. M. Keane, M.D., Appleton
W. H. Heywood, M.D., Marshfield
Otto A. Dittmer, M.D., Ripon
Francis M. Forster, M.D., Madison
W. J. Urben, M.D., Madison
Henry Veit, M.D., Milwaukee
Edward E. Haufek, M.D., Sheboygan
J. T. Petersik, M.D., Oshkosh
G. B. Tybring, M.D., Madison

The Division currently faces the basic issue of state planning for mental health and mental retardation, with subordinate individual issues closely or remotely involved with this theme.

The present problem is the existing gap in immediate and adequate psychiatric care for a significant portion of the population of the State of Wisconsin in rural and urban areas.

The State Comprehensive Mental Health Planning Committee, under the State Department of Public Welfare, is the policy-making coordinate body acting through steering, district and county level committees. The central planning committee and the Steering Committee on Mental Health each include one division member representing SMS. District and county level committees also include some physicians. By motion of the Division, Dr. A. A. Lorenz, Eau Claire, its member on the central planning committee, reports directly to the Council as well as to the Division at each of its meetings.

The Division is gravely impressed by the fact that need for psychiatric services necessitates planning and action. Plans formed now may well set up patterns of mental care for the coming decade or longer. The Division is concerned as to how to reach medical doctors with a realization of the importance of their individual "grass roots" participation in present planning, and their local action in mental care as private practitioners dovetailing their abilities with the use of existing federal and state legislative monetary allocations, without loss of their private practice posture. A gap exists which must be met either by extension of private practice of medicine utilizing government sponsored structures or by necessarily increased dimensions of state care. Concomitant with either alternative is a mushrooming of various agency services by social workers and psychologists, laudable each in their own right, but bearing portent of future danger in the care of the mentally ill if these services extend in breadth without the involvement of interestedly active physicians, private and/or state.

The Division wishes to commend Leonard Ganser, M.D., on his formation of a central planning committee representative of many disciplines and interests but not involving state government as such in its membership. The Division points out, however, that an invitation is still being extended to private medicine and private groups to assume a role. If unaccepted, other partially medical or quasi-medical agencies will necessarily assume our role. At present, and for the foreseeable future, care of the mentally ill is government dominated for the most part. It is the history of psychiatry, starting in ancient Greece, that when the core of the care of the mentally ill is rejected by the physician the care deteriorates and is taken up by the temple priest,

the Inquisitor, the Salem clergyman or the law of the state. Individual psychiatrists and physicians need now find ways in their own locale to serve the existing needs through some manner of contract of use with the publicly sponsored agencies and institutions, bringing abilities as private practitioners, but not losing posture as such.

In the context of the above, the following positive and negative decisions were reached by the Division:

1. After extended ad hoc committee and full Division discussion with invitees from the State of Wisconsin Mental Health Advisory Committee, the Academy of General Practice, the Institutions for the Retarded and the Division of Mental Hygiene, the Division rejected a plan for sponsoring courses for the general practitioner regarding the mildly retarded child. The reasons were as follows:
   a. The expressed view was that the general practitioner is interested primarily in referral of these cases and would be unlikely to attend a course on the subject. This view was confirmed by the fact that an excellent one day symposium on retardation presented by the Wisconsin Psychiatric Institute attracted 390 registrants of whom twelve were physicians (including university M.D.'s). We still feel we would like to try a one day program for physicians only, combining pediatricians and psychiatrists, under the joint sponsorship of the Wisconsin Chapter of the American Academy of Pediatrics, Wisconsin Chapter of AAGP and SMS.
   b. For the non-physician, yearly Institutes on the Slow Learner are already given annually in differing areas of the state by a group headed by John B. Toussaint, M.D., of Central Colony. These follow his arrangement with the late Edward D. Schwade, M.D., in 1959 and are very useful to the public but few or no physicians attend.
   c. Endorsement was given by the Division to the preparation of a one sheet tear-out for the *Wisconsin State Medical Journal*, to list concisely for reference the places to which a practicing physician can refer a suspected case of mental retardation.
2. Regarding postgraduate education in psychiatry for the general physician, the Division expressed conviction that programs at local general hospitals or at county society meetings would be the most useful device. The Division rejected the concept of monthly meetings at the State Medical Society Office in the conviction that at best only Madison area physicians might attend.
   The Division has endorsed A. A. Lorenz, M.D., in his seeking support from the Society and the Wisconsin Psychiatric Institute for a Symposium on Depression to be offered in Eau Claire by the Northwest Psychiatric Clinic on April 8, 1964. The symposium is for physicians only and without fee; it presents two in-state speakers and five out-of-state speakers. It is hoped that a series of courses can be developed in the near future for presentation in various localized areas of the State.
3. After extended discussion the Division rejected the concept of forming a State Medical Society sponsored mental health planning committee, since it would duplicate the private agencies and private resources already represented on the Department of Public Welfare Planning Committee. The Division believes much planning and study have already been done through five years past by the Citizens' Advisory Committee to the Board of Public Welfare and by the State Mental Health Advisory Committee (the "Governor's Committee"). The Division has no quarrel with the findings of these committees and believes the current real need is not for more planners but for active, involved participation in work performed at a local community level by local doctors of medicine, especially psychiatrists, without giving up their private practice stature.
4. The Division was well represented at the First AMA Congress on Mental Health and at the Tenth Annual AMA Conference of State Mental Health Representatives. It was noted that Congress attendance was predominantly non-physicians in the mental health field. It was noted at the Congress and at the Conference that the AMA is stressing the need for local level physician participation in planning and action towards development of practical care for the large body of mentally ill.
5. The Division hosted a meeting of the State Mental Health Advisory Committee on September 13, 1963, with the primary focus on county hospital development towards local treatment capacity. The Division recommends that the State Medical Society strongly support Bill 170, S., which, in essence, changes State reimbursement in such a manner as to encourage counties to develop local care, and to prevent counties from profiting from State average reimbursements by keeping county hospital care inferior and cheap.
6. The Division was host to H. C. Everett, M.D., of Mendota State Hospital, hearing his plans regarding education of general physicians in aftercare. The Division expressed itself of the conviction that practical teaching of this kind would be most useful, but should be at a local community level.
7. In accord with AMA recommendation and Commission on State Department's request, the Division spent segments of three meetings on addictive drugs. Conclusions were:
   a. A brief statement warning danger of withdrawal symptoms, including convulsions and death, with overuse of certain tranquilizing or psychic-energizing drugs was prepared by a Division member for black-framed publication in the *Wisconsin Medical Journal*.
   b. A triad of Division members agreed to prepare regularly a semi-annual short article for the *Wisconsin Medical Journal*, specifying by name certain new drugs with danger of such withdrawal symptoms.
8. The Division reviewed and referred to its Subcommittee on Commitment Laws the problem of the current sex crimes statute prohibiting issuance of a driver's license to persons paroled under that statute.
9. The Division reviewed legislation prohibiting payment of medical care to public assistance recipients who are in a general hospital primarily because of a diagnosis of psychosis. Bill 389, S., had attempted to correct this inequity and had been defeated in the Senate in August, 1963. The Division asks that the Society urge re-introduction of this Bill and support its passage.
10. Subcommittee on Commitment Laws:
    This Subcommittee remains actively aware of some Wisconsin laws that need change in their

pertinence to management of facets of behavior of the mentally ill. Long-term unresolved issues have to do with sanity before the court and commitment of the mentally ill. In addition to discussion on the above, the Subcommittee accomplished the following:

a. The present driver's license renewal question pertaining to "legally adjudged insane" is useless, as two years may elapse before the question is raised following hospital discharge. Corrective legislation has been formulated to require each hospital superintendent to report to the Motor Vehicle Department the name of any committed patient who has left the institution and who is, in his opinion, possibly unsafe to drive. Burden of final decision is left with the Motor Vehicle Department. The Division recommends that this bill, prepared by conjoint deliberation of the Subcommittee, a Judge of County Court, a Judge of Circuit Court and Motor Vehicle Department representation, be introduced in the legislature by the State Medical Society and supported for passage.
b. Aware of the fact that there is no current proof that auto accident incidence is higher among previous mental patients, the Division has asked that the Motor Vehicle Department, in cooperation with other State Agencies, conduct a statistical analysis of committed patients. This is to be made during the ensuing several years as a partial attempt to bring out facts.
c. The question of the management of the sociopath, in ways promoting public safety and yet preserving the offender's rights, occupied much of the Subcommittee's time in conference with penologists, legal experts, sociologists, and county and circuit court judges. A formulation pertaining to the management of the "dangerous offender" was prepared and referred to experts in criminal law for draftsmanship. Upon completion it will come to the Division for review.

11. Community Mental Health Clinics were the subject of three Division meetings, with representatives of the Division of Mental Hygiene of the State Department of Public Welfare cooperating, pursuant to a request for a study of such clinics from the House of Delegates at its May, 1963 session. The Division has formulated the following statement and recommends its adoption:

    The quality of community mental health clinics varies greatly and we believe they are advancing into more practical usefulness in some areas. The concept of locally based care as exemplified by these clinics is endorsed by the Division. They are usually very capably staffed. It is the opinion of the Division that in some areas of the State the clinics are insufficiently involved in the pressures and urgencies of community needs that are the lot of the private practitioner of psychiatry, and that the clinics can tend to become self-perpetuating in this role.

    While the efficiency of the clinics per unit of staff care has increased during the past four to five years, as evidenced by the tripling of patient load while doubling the staff the Division is still concerned as to the cost of operation in comparison to private care. Also, the clinics do not assume a full medical responsibility in that they do not operate on a 24-hour per day basis.

    It is the opinion of the Division that more of these useful clinics should broaden their range of care and involve, usually by private contract, not only psychiatrists but also general practitioners in the hope that, in each community, the clinic may move toward more conscientious integration in the mainstream of practice of community medicine. The Division believes this cannot be accomplished by directives from the State alone, but has to depend upon responsible involvement of local medical practitioners, especially psychiatrists. These clinics are ordinarily under the responsibility of the county board, usually with a part-time director who is a privately practicing psychiatrist.

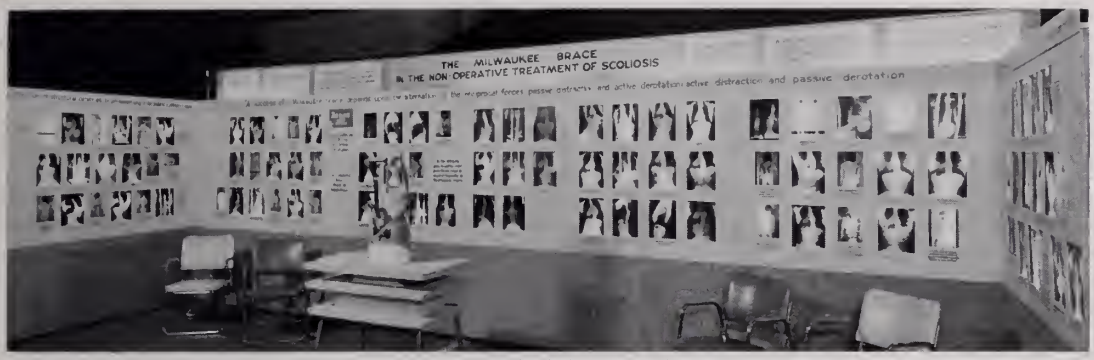
    The Division is hopeful that continuing review of the activities of the clinics by the local medical society will be carried out and that more interest will be shown by local physicians in these activities.

12. Certification of Psychologists:
    Pursuant to appointment by the Division in February, 1963, an ad hoc committee prepared tentative legislation regarding the practice of psychotherapy. This is under review by the Division. For about ten years the Division has rejected requests from psychologists to support legislation aimed at certifying their status, and the Division has invariably stated its conviction that the practice of psychotherapy is the practice of medicine. However, psychotherapists (psychologist or social worker) are being used in treatment throughout the State. Basically, a form of inclusion of psychotherapists under the Medical Practice Act is under consideration, in a pattern similar to that used with physical therapists, under medical supervision.
13. Individual Division members served as officers of the Wisconsin Psychiatric Association as panelists or speakers at meetings of the AMA 10th Annual Conference of State Mental Health Representatives, the Annual Meeting of the Wisconsin Psychiatric Association, the Public Hearings of the State of Wisconsin Mental Health Advisory Committee, the Annual Meeting of the Wisconsin Association for Retarded Children, the State Medical Society's Work Week of Health, and other meetings.

■ REPORT OF DIVISION ON REHABILITATION OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

Paul A. Dudenhoefer, M.D., Milwaukee, Chairman
Harry D. Bouman, M.D., Madison
Louis Kagen, M.D., Milwaukee
R. E. Housner, M.D., Richland Center
C. E. Koepp, M.D., Marinette
R. L. Gilbert, M.D., La Crosse

The Division has recently met under its new chairman and considered several areas of concern. One item which has been before the Division for review is the Old Age, Survivors and Disability Insurance program administered by the Department of Health, Education and Welfare under the Federal Social Security Act. The Federal government operates the disability benefits portion of the program through the Division for Vocational Rehabilitation of the



SCIENTIFIC EXHIBIT: SECOND PLACE—Large Hospitals. "The Milwaukee Brace in the Nonoperative Treatment of Scoliosis" by Drs. W. P. Blaunt and J. H. Moe, and R. G. Bidwell, R.O., Marquette University, Milwaukee, and University of Minnesota, St. Paul.

State Board of Vocational and Adult Education. The function of the state agency is to review applications from Wisconsin residents and determine whether they have a medical impairment of sufficient severity to prevent engagement in gainful activity which would be of long-continued and indefinite duration.

It is important to note that the determination of eligibility must be an independent one of the State agency, based on objective medical evidence furnished by the applicant from his family physician, hospitals and other sources of medical care and treatment. In making the determination of eligibility the agency is also required to consider factors other than physical or other medical impairment, such as the applicant's age, whether he has satisfied the earnings requirement, past work experience, educational attainment, etc. However, because the medical information is vital to this overall evaluation the agency is empowered to arrange and pay for medical consultation where the evidence submitted suggests that an impairment does exist which would meet the criteria, but in which there is either some conflict in the evidence or it is insufficient to clearly establish the degree of impairment and remaining functional capacities. Since it is in the area of consultative examinations that physicians may raise objections or questions concerning the program's operation, the Division has explored this matter with representatives of the State agency involved in making the determinations. We note that consultation is requested in about 30% of the cases, and that a survey conducted over a two-month period a year ago indicated that about 51% involved internal medicine, 11% orthopedics, 24% neuropsychiatric and 2% surgery. Where sufficient medical information is lacking the agency first obtains the patient's consent to submit to an examination by a consultant, then arranges for the examination and then reimburses the applicant for his costs of transportation and pays the examining consultant's fee according to a fee schedule agreed to by the State Medical Society. It was noted that the agency is not empowered to pay the family physician for the initial report which he submits on behalf of the patient-claimant. This is the patient's responsibility if the physician makes a charge for such reports.

The disability determination agency emphasizes, and we do so here, that the determination of "disability" is quasi-judicial in nature and solely their responsibility, involving as it does an evaluation of all facts presented. Physicians are asked to neither encourage nor discourage patients in filing claims for benefits and to refrain from recommendations concerning "disability."

The size of this program is pointed out by the fact that $20 million will be paid in benefits to disabled workers and their families in Wisconsin during the year 1964. The average disability insurance payment is about $90.00 per month. An estimated 9,700 applications will be adjudicated during the fiscal period 1964–65, with a denial rate of about 33 to 40%.

County medical societies wishing more information about the operation of this program in Wisconsin are urged to contact the Rehabilitation Division of the Board of Vocational and Adult Education and ask that a personal representative appear at a medical society meeting to explain its operation and answer questions concerning it. The Division also recommends an article in the *Wisconsin Medical Journal* on this subject.

The Division also discussed the fee schedule now being used by the Board of Vocational and Adult Education, agreed to by the State Medical Society in 1959. We note that this schedule appears inadequate in many areas and recommend that a new schedule be negotiated by the appropriate committee of the Society at the earliest possible date.

A project was considered by the Division some time ago, following a recommendation by the American Medical Association, to prepare a comprehensive directory of rehabilitation services. The Division is pleased to learn that the State Board of Vocational and Adult Education's Rehabilitation Division is in the process of preparing such a publication, by district, covering the State of Wisconsin. The Division hopes to review the material completed at the time of its next meeting and discuss possible ways the State Medical Society can participate in the program in order that copies may be made available to all physicians.

The chairman attended the Midwest Regional Institute on Public Health and Rehabilitation held at the University of Chicago on September 27 and 28, 1963. In reporting to the Division, it was pointed out that this was the second of a series of regional conferences held in an attempt "to identify the merging interests, the common problems, and the evolving relationships between Public Health and Rehabilitation." The Division reviewed with interest the activities of the state agencies in the area of rehabilitation projects. We note that the State Board of Vocational and Adult Education's Rehabilitation Division is establishing a very ambitious pilot project in Wood County, the first of its kind in the State of Wisconsin. This project is intended to formulate a model rehabilitation community with appropriate surveys of existing facilities, services, needs and desires. Local interest appears quite high, particularly by the physicians in the area who turned out for a recent hearing on the project. Costs of the project will be shared between federal, state and

local funds. The Division has been asked to consider endorsement of the project by the State Medical Society but has delayed making any recommendations until a complete resume of the program can be studied.

The Division has also received a report of the State Board of Health activity in the area of rehabilitation activity. It is understood that a physical therapist is now employed in each of the eight district offices and that four occupational therapists and one rehabilitation nurse have been added to the Board of Health staff. Although this service is primarily aimed at registered nurses and licensed practical nurses, some services are provided individual patients with the permission and cooperation of the patient's physician. We are pleased to note that the cooperation and support of physicians has reportedly been excellent.

■ REPORT OF DIVISION ON SCHOOL HEALTH OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

L. M. Simonson, M.D., Sheboygan, Chairman
William T. Brodhead, M.D., Madison
Frances A. Cline, M.D., Rhinelander
E. E. Bertolaet, M.D., West Allis
James C. H. Russell, M.D., Fort Atkinson
Horace K. Tenney, III, M.D., Madison
F. W. Reichardt, M.D., Stevens Point

College Health Services

Colleges and universities in Wisconsin, in recent years, have experienced a considerable increase in enrollment; one of the effects of this trend has been on the student health services of these institutions.

An example of this came in the form of a request from the President of Whitewater State College for advice from the State Medical Society in reorganization of the health service at his college. Representatives of the Division, the County Medical Society, and the American Medical Association met with the President and his staff and made their recommendations.

The Division sees a need to review present conditions and anticipate further requirements of the colleges in the state, particularly the state college system which is experiencing rapid expansion. It recommends that the matter be placed before the Board of Regents of State Colleges and the appropriate bodies of private colleges in the state, with an offer of Society assistance in establishing standards for college health services in Wisconsin.

Liaison with State Agencies and Organizations

The Division has maintained a close liaison with the Department of Public Instruction, the State Board of Health, and the Wisconsin Interscholastic Athletic Association. In this connection it has the following matters to report:

In previous years, liaison with the W.I.A.A. has been accomplishd through a Subcommittee Advisory to that organization. In 1963 this subcommittee was discontinued and liaison with the W.I.A.A. is now a function of the entire Division.

The Department of Public Instruction and the Wisconsin Division, American Cancer Society, are to be commended for their joint distribution of information packets entitled "Smoking and the Health of Youth" to schools in the state.

The Division reviewed the "Continuous Health Supervision" program of the Wisconsin Parent-Teacher Association and found it generally sound. The program encourages periodic medical and dental examinations, immunizations, health education, and keeping of health records.

Date _____

REPORT TO SCHOOL ON SIGNIFICANT FINDINGS OF HEALTH EXAMINATIONS

Name of Pupil _____

School _____ Grade _____

Name of Parents _____

Address _____

Medical conditions of significance to school authorities:

_____

_____

_____

_____

Is the pupil incapable of carrying a full program of school work? _____ Yes ___ No ___

Should there be restrictions on up and down stairs travel? _____ Yes ___ No ___

Is special seating recommended? _____ Yes ___ No ___

Does pupil have irremediable defects? __ Yes ___ No ___

Is there evidence of emotional or behavior problems? _____ Yes ___ No ___

Is there a need to restrict physical education activity? _____ Yes ___ No ___

Should physical activity outside of school be limited? _____ Yes ___ No ___

Please elaborate on any recommended restrictions from normal school activity including nature and duration:

_____

_____

_____

_____

Please indicate, for purposes of follow-up, need for any specific medical, dental, psychiatric or surgical care including immunization: _____

_____

_____

_____

_____

Should child be seen again prior to next school physical examination? Yes ___ No ___

If yes, how soon? _____

Date _____

Signature of Physician _____

Address _____

To Be Filled Out By School Personnel

Action taken on above recommendations: Date

_____ _____

_____ _____

_____ _____

_____ _____

School Health Examinations

The Division has reviewed the Society publication "School Health Examinations" and recommends that it not be reprinted. It suggests that the State Board of Health and State Department of Public Instruction, with representatives of the medical and dental

professions, publish a booklet for educators and that the Society publish such information for physicians in the *Wisconsin Medical Journal.*

A "Health Examination Form," revised and simplified by the Division, has been tested in selected schools and has met with the approval of physicians, schools, and school nurses. It is recommended that this form, which is attached to this report, be endorsed by the State Medical Society for use in all schools in the state.

Physical Fitness

Since physical fitness, or lack of it, has such an important bearing on an individual's present and future health, the Division feels that continued and increased physician support is needed for the physical education programs, for both boys and girls, in our state. Recent legislation eliminated a requirement for 150 minutes of physical education instruction per week in Wisconsin schools. While the Division does not disagree with this action, it is concerned that removal of the statutory requirement may result in de-emphasis of physical education programs in some schools.

Use of Oxygen for Athletes

It has come to the attention of the Division that oxygen kits are being sold to schools for use by athletes during athletic competition. It is the opinion of the Division that since there is no beneficial effect, and a remote possibility of danger, involved in the indiscriminate use of these oxygen devices, that oxygen be used only for medical purposes under the direction of the team physician.

■ REPORT OF DIVISION ON VISUAL AND HEARING DEFECTS OF COMMISSION ON STATE DEPARTMENTS—MAY, 1964

Meyer S. Fox, M.D., Milwaukee, Chairman
Donald A. Peterson, M.D., Madison
George Nadeau, M.D., Green Bay
Richard J. Fogle, M.D., Racine
W. B. Larkin, M.D., Marshfield
James V. Bolger, Jr., M.D., Waukesha
Richard H. Brodhead, M.D., Wausau
C. G. Reznichek, M.D., Madison
John B. Hitz, M.D., Milwaukee

Activities of the Division during the past year have included review of the need for an additional eye bank in Wisconsin, use of the title "Doctor" by non-physicians in advertising eye referral services, legislation affecting visual health, recommendations to the Industrial Commission concerning adoption of the AMA Guide for Determining Loss of Visual Efficiency and continued review of the hearing conservation program of the Department of Public Instruction.

Eye Banks in Wisconsin

The Division gave consideration to a request for a recommendation concerning the establishment of an additional bank in Wisconsin, outside of Milwaukee County. In considering this matter, the Division recognizes the fact that the Wisconsin Lions Foundation has taken over the lay management and financial responsibility of the Milwaukee Bank, and that it plans to expand, as soon as feasible, and establish branch banks in other areas of the State. At the present time eyes are being collected only in the Milwaukee area, but distribution is to any qualified opthalmologist in the State of Wisconsin. The Division recommends that the expansion of the collecting facilities of eye banks into other areas of the State be done with due deliberation, inasmuch as the methods and facilities for moving the eyes and delivery to a central eye bank must be set up well in advance of any publicity given to such a collecting station. The poorest public relations an eye bank can have is publicity regarding the need for eyes, and then inability to remove the eyes and utilize them properly in research or in corneal transplant. It is, therefore, strongly recommended that no further eye bank facilities be set up in Wisconsin until the Milwaukee Eye Bank is functioning at full capacity, and that additional branch collecting banks be set up under the auspices of the Wisconsin Lions Foundation which is state-wide in its operation.

Use of the Title "Doctor" in Relation to Eye Care

The Division has been concerned with advertisements by optometrists in which use is made of the title "Doctor," and in particular in relation to an "eye doctor" referral service. Recognizing the confusion which often results to the public in the use of this title in relation to health care, and in view of the legal proscription on its use, the Division feels that this is a problem area requiring active consideration.

It is recommended that a positive program be developed toward the ultimate goal of curbing abuse of this title.

Legislation Affecting Visual Health

The Division has reviewed recent legislative proposals affecting visual health in Wisconsin. We note that Bill 133, A., was killed in the current session of the Legislature and express the hope that Bill 134,A., realizes the same result. Legislative matters affecting visual care have been referred to the Division's Sub-Committee on Visual Defects and its members have been very active in this matter. A more extensive report on the above legislation was contained in the report of the Commission on Public Policy to the House of Delegates last fall. The Division wishes to impress on the membership the significance of such legislation on all areas of medical practice.

Industrial Commission Rules for Determining Visual Efficiency Under the Wisconsin Workmen's Compensation Act

For some time the Division has been studying the status of the present Industrial Commission rules for determining loss of visual efficiency. A committee was appointed two years ago to consider this matter and study the Guide prepared in 1958 by the American Medical Association. This latter Guide is substantially more up-to-date than the present rules adopted by the Commission in 1941. The Division recommends that the Industrial Commission adopt the AMA Guide and offers its assistance to the Commission in setting up the new rules. To further the implementation of the proposed new rules, the Division suggests that a review be conducted to determine their effect, if any, on selected Workmen's Compensation cases paid under the existing rules and has offered the services of individual members to assist the Industrial Commission in doing so.

Speech Deterioration for Persons Over Age 21

The Division noted that the hearing conservation program of the State Department of Public Instruction cannot concern itself with persons over age 21, and that many persons beyond that age incur speech deterioration as a result of hearing loss, unknown or not recognized by them. The Division recommends that the State Board of Vocational and Adult Education be asked to review its programs to determine whether something can be done to provide the neces-

sary facilities and services to cope with this problem, if such are not presently available.

Training Course for Audiometric Technicians

The Division is proceeding to set up the series of instruction courses for audiometric technicians, approved by the House of Delegates last May. It is intended that the courses be self-supporting and located in three or four areas of the State, preferably in conjunction with extension schools of the University of Wisconsin. The cooperation and support of industry and all practicing physicians is being asked in order that personnel doing these very important audiometric tests receive proper instruction.

Visual Screening Program

The Division wishes to remind all physicians that a guide was developed several years ago as an outline to facilitate the development of a School Vision Screening Program. It has been noted by the Division that this guide needs re-emphasizing and recommends that the Commission on State Departments communicate with the State Board of Health, asking that the Board keep the local boards of health and public health nurses cognizant of this publication and the principles contained in it.

■ 1963 ANNUAL REPORT OF COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D., Prairie du Chien, Chairman
Robert Krohn, M.D., Black River Falls, Vice-chairman
Charles Benkendorf, M.D., Green Bay
G. W. Carlson, M.D., Appleton
M. D. Davis, M.D., Milton
K. H. Doege, M.D., Marshfield
Milton Finn, M.D., Superior
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
J. H. Houghton, M.D., Wisconsin Dells
D. A. Jeffries, M.D., Shawano
E. P. Ludwig, M.D., Wausau
P. B. Mason, M.D., Fond du Lac
Howard Mauthe, M.D., Fond du Lac
A. J. McCarey, M.D., Green Bay
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Modison
L. O. Simenstad, M.D., Osceola
J. T. Sprague, M.D., Madison
F. H. Wolf, M.D., La Crosse
W. J. Egan, M.D., Milwaukee
W. P. Curron, M.D., Antigo

Wisconsin Physicians Service paid its 68th millionth benefit dollar in December, 1963. From annual claim payments of less than $100,000 in 1947, WPS has grown so that it was able to pay more than $11,000,000 in health care benefits during the past year.

To adequately handle an ever-increasing volume of business, WPS has had to increase service and efficiency through electronic data processing, expansion of field personnel, the upgrading of subscriber coverage, and continuous internal efforts to achieve better performance.

Although growth in surgical-medical coverage has been the most pronounced, WPS has shown steady increases in hospital and major illness coverage. Allied health care coverage such as the Rx Prescription Contract and expanded benefits for many WPS subscribers have also contributed to a healthy growth picture.

Detailed statistical information to accurately depict WPS's present sound financial condition and growth pattern can be found throughout this report and in the attached financial statement. However, a report of progress would not be complete without reviewing the fundamental purpose of WPS: To serve as a leader in providing voluntary health care coverage in new and undeveloped areas.

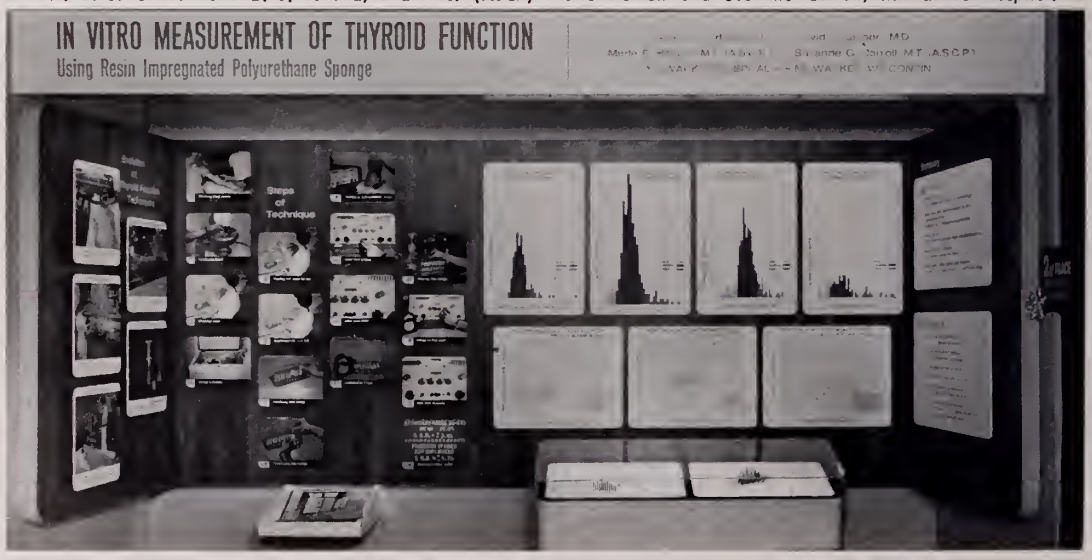
During 1963 WPS demonstrated its efforts to expand voluntary health insurance by:

Sponsoring a Conference on the Extension of Voluntary Health Insurance.

Working with the Governor's Commission on Aging to promote Major Illness coverage for persons 65 and older.

Marketing an Rx Benefit Contract to provide coverage for legend drug costs.

SCIENTIFIC EXHIBIT: SECOND PLACE—Smaller Hospitals and Individuals. "In Vitro Measurement of Thyroid Function" by Drs. D. J. Carlson and D. J. LoFond, and MTs. (ASCP) Marie Heinen and Suzanne Carroll, Milwaukee Hospital.



Developing a Prepaid Dental Benefit Contract to provide individual and family dental coverage for groups.
Continuing its strong promotion of Special Service with its "usual, reasonable and customary" fee concept.
Accelerating its efforts to cover more senior citizens under Century Plan policies.

Its growth pattern, sound financial structure and continued pioneering efforts have enabled Wisconsin Physicians Service to contribute substantially to the advancement of voluntary prepaid health care in Wisconsin during 1963.

Earned Premiums

The rapid increase in WPS earned premiums during the past several years must in small part be attributed to the increasing cost of health care and resultant rate increases. But there are two equally important factors in this rise: Constant enrollment increase and improved subscribed benefits.

The table below reflects the growth of WPS in surgical-medical coverage and its entry into such fields as hospitalization, major medical and pharmaceutical coverage. It also reflects new endorsements providing additional benefits, the up-grading of existing contracts, and the tailoring of the Century Plan to provide increased benefits.

EARNED PREMIUMS

1960	$ 9,164,209
1961	9,707,643
1962	11,034,739
1963	13,238,864
1964*	15,500,000

*Anticipated.

It is interesting to note that anticipated 1964 earned premiums of $15,500,000 will nearly treble that of seven years earlier.

Subscriber Benefits

The payment of benefits for health care service is, of course, a primary purpose of WPS. Continuous effort is made to pay all legitimate claims equitably and promptly. Yet, simple arithmetic tells us it is not economically sound over any long period to pay out more in benefits than is received in the form of premiums.

WPS maintains a constant vigil through its claims personnel, Medical Consultant, and the County Insurance Advisory mechanism to control benefit payments within contract provisions. Underwriting personnel and the Actuarial Consultant continuously review rates to insure that each phase of coverage stands on its own financial feet to the extent that this is practicable. The success of these efforts to achieve reasonable stability of benefit utilization is indicated by the following percentage of claims incurred to earned premiums.

CLAIMS AS A % OF PREMIUMS

	Surgical–Medical	Hospital	Total
1960	85.82%	88.77%	87.20%
1961	82.10%	84.77%	83.38%
1962	84.10%	87.86%	85.81%
1963	85.16%	88.48%	86.64%
1964*	85.00%	88.00%	86.50%

*Anticipated.

Operating Expenses

Rapid expansion brings with it many problems, but it also presents challenging opportunities for improvement in operating efficiency. While operating expense dollars have increased with growth, they must properly be evaluated by comparison with earned premiums.

The expense ratio in the third column of the table below demonstrates a downward trend. Not only has WPS reached the 12% objective set in 1961, but is now nearing the 11% mark. The 1963 operating expense ratio of 11.4% is statistical evidence of the never-ending effort to improve operating efficiencies.

ADMINISTRATIVE EXPENSES

Year	Amount	% of Prem.
1960	$1,104,685	12.1
1961	1,128,709	11.6
1962	1,299,648	11.8
1963	1,513,193	11.4
1964*	1,743,750	11.3

*Anticipated.

It is confidently predicted that as Wisconsin Physicians Service continues to grow and as newly installed electronic data processing equipment is more fully utilized, the operating expense ratio will continue its favorable downward movement.

Investment Income

Investments and the income which they generate also play an extremely important part in WPS operations. Approximately 40% of the addition to reserves in 1963 came from this source.

There has been a steady improvement in investment yield since 1960. The increased percentage of return is due in some measure to the observance of investment counsel recommendations.

INVESTMENT INCOME

Year	Amount	% Return
1960	$ 85,798	2.93%
1961	113,665	3.68%
1962	148,669	3.81%
1963	185,190	3.90%
1964*	210,000	4.00%

*Anticipated.

Reserves

"Total Reserves," simply stated, are the funds which would remain if all obligations were met as of the date of the statement in which such figures appear. They represent added assurance of financial stability and protection for all WPS subscribers.

The steady growth shown by the Reserves table below reflects WPS' efforts to provide sound subscriber protection. Reserves have almost doubled from 1960 to 1963 and future operations will be closely watched to insure a continued healthy financial condition.

RESERVES

December 31	Amount
1960	$1,454,938
1961	2,016,752
1962	2,479,817
1963	2,877,262
1964*	3,400,000

*Projected.

COMMISSION ON MEDICAL CARE PLANS
Members, Staff, and Consultants

Seated around the table (left to right): Dr. C. G. Reznichek, Madison; Dr. F. H. Wolf, La Crosse; Dr. G. W. Carlson, Appleton; Dr. K. H. Doege, Marshfield; Dr. J. T. Sprague, Madison; Dr. R. M. Moore, Frederic; Dr. L. O. Simenstad, Osceola; C. H. Crownhart, Madison (secretary-general manager); Dr. E. M. Desslach, Prairie du Chien (chairman); Dr. Milton Finn, Superior; Dr. Howard Mauthe, Fond du Lac; Dr. W. J. Egan, Milwaukee; Dr. J. H. Houghton, Wisconsin Dells; Dr. Charles Benkendorf, Green Bay; Dr. M. D. Davis, Milton; D. C. Reynolds, Madison (staff); and Dr. W. P. Curran, Antigo.

Seated at the rear left: Miss Pat Moran and Miss Joan Pyre (staff). Standing (left to right): Roger Sumnicht, Madison (staff); Herman L. Toser, Madison (insurance consultant); R. B. Murphy, Madison (legal consultant); T. J. Doran, Madison (staff); Dr. C. O. Vingom, Madison (medical consultant); C. A. Tiffany, Chicago (actuary); R. E. Koenig, Madison (insurance director); and J. B. White, Madison (certified public accountant).

Seated at the rear right (left to right): E. R. Mulady, K. C. Sprain, A. H. Gardner, J. H. Blaine, J. J. Murphy, and F. T. Thatcher, all of Madison (staff).

Commission members not present: Dr. Robert Krohn, Black River Falls (vice-chairman); Dr. D. N. Goldstein, Kenosha; Dr. A. W. Hilker, Eau Claire; Dr. D. A. Jeffries, Shawano; Dr. E. P. Ludwig, Wausau; Dr. P. B. Mason, Sheboygan; Dr. A. J. McCarey, Green Bay; and Dr. E. J. Nordby, Madison.

Enrollment

Contract count in 1963 exceeded the 200,000 mark. Comparison with the previous year shows substantial gains in all categories.

	12-31-62	12-31-63
Surgical-Medical	115,953	130,080
Hospital	48,154	58,151
Major Medical	22,378	28,286
Prescription Drugs	---------	1,828
Total	186,485	218,345

An important factor in continued expansion is that of retaining "old" subscribers. It is even more important as evidence of the efficient service and proper management so necessary to health operation.

WPS retained a high percentage of "old" subscribers, including such large groups as General Motors, State of Wisconsin Employes, and American Motors. In addition, new benefits were added for many groups of varying size.

Contract count does not reflect the results of continued efforts to "upgrade" subscriber benefits. The "upgrading" of subscribers from "B" to "A" schedule coverage and to Special Service substantially increased benefits throughout the state. In fact, contract count now shows that more than 65% of WPS surgical-medical coverage is Special Service.

Enrollment increases have by no means been limited to group additions. Non-group sales efforts have carried coverage to many new geographical areas of the state. Century Plan contracts now number more than 13,000—providing, in most cases, both surgical-medical and hospital benefits.

Efforts to provide WPS subscribers with coverage adequate for current economic conditions will continue in 1964.

Claims Payment

The 1963 growth in enrollment resulted in benefit payments to physicians and hospitals totaling $11,120,110. This was an increase of almost $2,000,000 over the prior year.

WPS paid 129,378 claims submitted by physicians on behalf of subscribers and 35,647 hospital claims. Claims volume rose 18% during the twelve month period.

The great majority of claims under the Special Service Contract were handled through direct processing by the Claims Department. Less than 1% required referral to County Advisory Committees. Since the Special Service Contract was introduced in 1956, only three claims have been brought before review committees of the State Medical Society.

Careful attention is given to benefit utilization so that necessary rate adjustments may be made when justified by "loss" experience.

Agency Expansion

In order to cover "the far corners" of the state and make WPS health insurance readily available to larger numbers of Wisconsin residents, the Agency Sales Department has rapidly expanded. The Agency Sales Department is geared to reach less accessible non-group subscribers whose needs are too often overlooked.

Promotion

WPS advertising continued to emphasize the Special Service Contract, as well as the Century Plan, Ready Reserve, Protection Plus and current group coverages.

Of a 1963 advertising budget of $106,790, almost $85,000 was spent on newspaper, magazine, outdoor billboards and direct mail. This compares with $79,000 spent on this media in 1962.

Non-group inquiries increased substantially to almost 500 per month in 1963 while group inquiries showed an even greater proportionate increase from 17 in 1962 to 185 in 1963.

Unquestionably, promotional activities contributed a great deal to the $2,200,000 increase in earned premiums during 1963.

Service and Research

Activity of the Research Department was centered in review of internal operations and in special projects covering many fields of voluntary health care.

Among projects completed:

- Restudy of efforts to provide benefits for migrant workers and their families.
- Survey to determine reasons for cancellation of direct pay business.
- Study of the surgical-medical loss ratio.
- Special studies relating to administration of claims under the Special Service Contract.
- Survey of field expense with particular emphasis on travel and related business expense.

In continuing efforts to speed up subscriber service, internal operations have been automated through installation of the IBM 1440 system. Although full impact of the data processing center has not yet been felt, it is certain to bring many time and expense saving advantages.

The Conference on the Extension of Voluntary Health Insurance, referred to earlier, brought together leaders representing all segments of the health care world. The insurance industry, government, physicians, hospitals, private agencies and consumers were all represented at the Conference. A complete report of the Conference is contained in the attached copy of an article which appeared in "National Underwriter."

During 1963 a contract reimbursing the cost of legend drugs was offered to present WPS subscribers and the public. Acceptance was satisfactory and national attention was focused on this pioneering effort.

For the first time WPS accepted applicants formerly considered "uninsurable" because of impaired health. These subscribers were specially rated, but their acceptance represents another assault on the problems faced by voluntary health insurance.

Medicare

Wisconsin physicians received $417,000 in payment for care of military dependents during 1963. Volume was less than 1962 because of the deactivation of Wisconsin's 32nd Division.

Along with these payments, Wisconsin also provided technical services assisting five other midwestern states in processing more than 17,000 cases totaling nearly $1,360,000.

Kerr–Mills

The Commission on Medical Care Plans worked closely with Wisconsin Health Service, a committee of the Commission, to implement Kerr–Mills (Health Assistance Payments Act) in Wisconsin.

Bids to determine the organization that will administer Kerr–Mills benefits in Wisconsin will be opened on Friday, March 13. A supplementary report will be made after results of the bidding are known.

Wisconsin Physicians Service
A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

CONDENSED BALANCE SHEET—DECEMBER 31, 1963

Assets		
Cash on Hand and in Banks		$ 214,394
Receivables		857,858
Government Securities—Market Value	$3,876,140	
Commercial Securities—Book Value	739,803	
Other Investments	621,828	
Total Investments		$5,237,771
Fixed Assets—Net		109,018
Accruals and Prepaid Expenses		83,076
Total Assets		$6,502,117
Liabilities and Reserves		
Payables		$ 60,938
Provision for Unreported and Unpaid Claims		1,900,000
Premium Received but not Earned		1,648,131
Other Liabilities		15,786
Total Liabilities		3,624,855
Total Reserves		2,877,262
Total Liabilities and Reserves		$6,502,117

Analysis of Reserves

	Month of Dec., 1963	12 Months Ending 12/31/63
Reserves—Beginning of Period	$2,772,865	$2,479,817
Add or (Deduct):		
Provided by or (Absorbed in) Operations and Investments	108,945	412,466
Increase or (Decrease) in Book or Market Value of Securities	(4,518)	(15,021)
Reserves—End of Period	$2,877,262	$2,877,262

Wisconsin Physicians Service
A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

Financial Statements—December 31, 1963

CONDENSED STATEMENT OF INCOME AND EXPENSES

	Month of December 1963	% of Premium	12 Months Ending Dec. 31, 1963	% of Premium	12 Months Ending Dec. 31, 1962	% of Premium
Earned Premium Income	$ 1,192,910	100.00	$13,238,864	100.00	$11,034,739	100.00
Benefits Incurred (Paid and Estimated)	977,149	81.91	11,469,516	86.64	9,468,532	85.80
Available for Expenses and Reserves	$ 215,761	18.09	$ 1,769,348	13.36	$ 1,566,207	14.20
Administrative Expenses	126,095	10.57	1,513,193	11.43	1,299,650	11.78
Net Operating Income	$ 89,666	7.52	$ 256,155	1.93	$ 266,557	2.42
Investment and Other Income (Net)	19,279	1.61	186,311	1.41	159,356	1.44
Total Available for Reserves	$ 108,945	9.13	$ 442,466	3.34	$ 425,913	3.86

Analysis of Premiums and Benefits

12 Months Ending December 31, 1963	Earned Premium Income	Benefits Incurred	Benefits Incurred as % of Income	Available For Expenses and Reserves
Surgical-Medical	$ 7,345,754	$ 6,255,299	85.16	$ 1,090,455
Hospital	5,893,110	5,214,217	88.48	678,893
Total	$13,238,864	$11,469,516	86.64	$ 1,769,348
12 Months Ending December 31, 1962				
Surgical-Medical	$ 6,018,400	$ 5,061,178	84.10	$ 957,222
Hospital	5,016,339	4,407,354	87.86	608,985
Total	$11,034,739	$ 9,468,532	85.81	$ 1,566,207

■ REPORT OF COMMITTEE ON HEALTH ECONOMICS OF AMERICAN LIFE (HEAL)—MAY, 1964

R. N. Allin, M.D., Madison, Chairman
G. C. Schulte, M.D., Kenosha
L. J. Kurten, M.D., Racine
R. A. Pribek, M.D., La Crosse
Millard Tufts, M.D., Milwaukee
Norbert Enzer, M.D., Milwaukee
D. J. Twohig, M.D., Fond du Lac
J. R. Heersma, M.D., Marshfield
George Nadeau, M.D., Green Bay
C. A. Olson, M.D., Baldwin
M. L. Whalen, M.D., Bruce
J. W. McGill, M.D., Superior
Members-At-Large
A. J. McCarey, M.D., Green Bay
S. J. Graiewski, M.D., Oshkosh

The Executive Committee of the Council in October, 1959, reported what it characterized as an "emergency recommendation" . . . that a committee be appointed with jurisdiction in the area of federal legislation.

The Committee on Health Economics of American Life resulted from this recommendation and is so organized that each member is practicing in one of Wisconsin's ten Congressional Districts.

The Committee has resolved that it should be primarily concerned with the King–Anderson Bill and other legislative approaches to medical care for the aged, but that all legislation affecting the health economics of American life be considered when the need presents itself in such a manner as to call for Committee action.

During the past year the Committee has limited its main course of activities to the King–Anderson approach to medical care for the aged and to the education of the profession and the public to the dangers inherent in this legislation. The Committee has also concerned itself with other approaches to medical care for the aged including the Javits Bill, the Bow Bill and the Lindsay Bill.

Federal legislation that was passed in the 88th session of Congress and reviewed by the Committee included the Mental Retardation Act, federal standards for seat belts and provisions for aid to medical education. Legislation still pending consideration includes proposals on air and water pollution, pesticides, narcotic hospital facilities and civil defense. Congressional control over legislation dealing with migratory workers and chiropractic and optometric legislation also await consideration.

In an April, 1963, meeting in connection with the National Legislative Conference in Chicago the Committee undertook the implementation of "Operation Hometown," the American Medical Association's legislative program designed to counteract the forces supporting socialized medicine, and has continued its activity in this area to date. Under the Committee's auspices the film dealing with "Operation Hometown" has been shown, thousands of pamphlets have been distributed and implementation of committee work has taken place at the county level.

The main concern of the Committee has been to transmit organized medicine's position on King–Anderson to the public, and to have the public and profession in turn make this position known in Washington.

This position, as it was stated to the House Ways and Means Committee is as follows:

> "Consistent with its statement presented before the Ways and Means Committee in 1961 on H. R. 4222, the predecessor of H. R. 3920, the State Medical Society of Wisconsin remains opposed to any King-Anderson type legislation on three grounds. One is philosophical and is comprised of professional, social and political elements. The second is the substantial number of technical errors and factual assumptions which permeate H. R. 3920. The third is the absence of any real need of federal intervention in providing even partial health care for the segment of Wisconsin's population aged 65 and over."

The Society in making this statement to the House Ways and Means Committee outlined the provisions of the Wisconsin Kerr–Mills law and pointed out that this law as designed, could alleviate any economic medical problems that the elderly population now faces.

In view of the fact that the "emergency situation" which was the purpose for creating this Committee still is very much in existence and promises to be for some time to come (see attached views of the present administration on FEDICARE) your members urge that constant vigilance in the area of King–Anderson type legislation and constant awareness are the only methods of preventing American medicine from the pitfalls of socialized medicine and in turn protecting sound public health.

To safeguard the public's welfare and to maintain sound public health, medicine must be kept free from political intervention. Participation in this issue by each and every Wisconsin physician is a must if basic freedoms are to be safeguarded, and Senators and Congressmen must be contacted now, and on a continuing basis. Public education has stopped the enactment of socialized medicine to date and must continue if there is to be a continued measure of success.

King–Anderson is a medical issue because it affects the health of all American citizens, but it is also a political issue because if the King–Anderson Bill is passed, a dangerous precedent will have been established by those forces who would take away our rights to choose as individuals. Time for action has been in the past, is at present and will continue to be in the future. Write your Congressman now.....

■ REPORT OF COMMITTEE ON GRIEVANCES—MAY, 1964

E. D. Sorenson, M.D., Elkhorn, Chairman
M. F. Huth, M.D., Baraboo
Donald K. Griffith, M.D., Eau Claire
J. D. Leahy, M.D., Park Falls
H. J. Belson, M.D., Manitowoc
R. R. Richards, M.D., Eau Claire
T. J. Nereim, M.D., Madison
E. W. Mason, M.D., Milwaukee
R. W. Mason, M.D., Marshfield

Ordinarily the majority of your Grievance Committee's time is consumed in reviewing complaints coming before it. During 1963 several other subjects were before the Committee, however, involving ethical aspects of medical practice. Even though the Principles of Medical Ethics of the American Medical Association are comprehensive in their embrace of ethical principles, a considerable number of questions do arise in their interpretation. For the most part inquiries can be answered by referral to the Opinions and Reports of the Judicial Council of the AMA. Where a void exists or a particular subject has been left to local and state societies for the setting of guides, the Committee attempts to provide a workable answer, within the framework of ethical principles, for approval of the Council of the State Medical Society, the authority for such pronouncements in Wisconsin.

One such subject before the Committee during the last year is the matter of professional courtesy. Questions have arisen regarding the application of the principle that "a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity." Some of the questions considered by the Committee concern the matter of what members of the family of a physician fall within this principle; at what age do children cease to come within the purview of the principle; does it apply in communities where the physician performing the services treats many student-dependents of physicians who reside outside of the community or even the state and reciprocity is, as a practical matter, impossible? Your Grievance Committee recommends that these issues be resolved by answering the questions on the individual facts presented, applying the principles and official interpretations of the AMA. It is our feeling that "dependents" as applied to this principle means persons dependent on the physician for their support and maintenance. We do think the principle applies in the situation of the physician rendering services to student-dependents of physicians, even though the physician parent is outside the community and unable to reciprocate the courtesy. We call to your attention a pronouncement by the Judicial Council to the effect that it is permissible for a physician or his dependents, who had been indemnified for the cost of medical care under an insurance or prepayment plan, to turn that indemnification or reimbursement over to the attending physician to reimburse him for his expenses. (Judicial Council, 1961)

Another matter which the Grievance Committee considered during the past year relates to advertisements of office furniture for clinics' or physicians' offices, usually in the *Wisconsin Medical Journal.* Such advertisements, which contain pictures of actual offices or clinics, are permissible so long as they do not identify by name or location the clinic or physician's office. We recommend adoption of this statement as a guide to Journal advertisers and physicians.

During 1963 the Grievance Committee had the pleasure of joining the Interprofessional and Business Relations Committee of the State Bar of Wisconsin for dinner and a meeting to discuss possible revisions of the Interprofessional Code between our two professions. It is hoped that this project can be continued in the near future in order that the existing Code cannot only be brought more into focus with present needs but that other proposals can be discussed.

It does not appear that the incidence of complaints concerning professional practices has increased in the last few years and this is viewed as a significant compliment to Wisconsin physicians. It is particularly encouraging in view of statistics arising out of some other states on malpractice cases. The membership should be cognizant of the fact that the Grievance Committee has an established policy to make no investigation of a complaint when a lawsuit has been started.

Fiscal Note:

No fiscal implication is intended by the recommendations contained in this report, for the current budget year. Completion of the revision of the Interprofessional Code would involve re-publication expense but this is not contemplated during the current year and a budgetary item will be submitted in advance of such publication.

■ REPORT OF COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS—MAY, 1964

D. E. Dorchester, M.D., Sturgeon Bay, Chairman
R. J. Botham, M.D., Madison, Vice-chairman
J. S. Devitt, M.D., Milwaukee
Louis Olsman, M.D., Kenosha
C. A. Olson, M.D., Baldwin
C. J. Picard, M.D., Superior
D. G. MacMillan, M.D., Barron
W. E. Acheson, M.D., Valders
J. E. Martin, Jr., M.D., Delavan

During the past year the Commission has directed its attention to special areas in rural health and

occupational health, as well as utilization of the news media in the state for health education and communication of matters concerning physicians and their Society. Particular emphasis has been placed on better utilization of television as a communications medium, while continuing programs directed to the newspapers and radio stations in the state.

Public Information

The Society is fortunate to have H. Kent Tenney, M.D., as program director of its "March of Medicine" radio series, currently being broadcast weekly over 51 radio stations and affiliates. His informative presentations and personal attention to mail received in response to programs comprise a valuable health education program. The Commission commends Doctor Tenney for his excellent work during the past year and reaffirms support of the series as a continuing project of the Society. It has in preparation a poster, for use in physicians' offices, to publicize the program and more closely identify the practicing physician with the series.

In the field of television the Society prepared, in cooperation with WHA Television in Madison, a 13-program series on Health Fads and Fallacies. The series was recorded on video tape and is being offered to television stations in the state to be telecast as a public service series. Also under preparation is a series of health education slides, for use during station breaks between television programs.

Occupational Health

Through its Committee on Occupational Health, and a joint committee of the Wisconsin Hospital Association, Wisconsin Nurses Association, Wisconsin State Board of Health, and State Medical Society, "A General Guide for an Occupational Health Program for Hospital Employees" has been developed and approved. It is anticipated that the guide will be valuable to hospital administrators and medical and nursing staffs in Wisconsin.

Rural Health

The Commission sees a need to expand its activities in the field of rural health, and is establishing a committee, similar to its Committee on Occupational Health, to work in this area, under direction of the Commission.

The past year has seen liaison with rural organizations and continuation of its award program to 4-H clubs in Wisconsin which have done outstanding work in the field of health. Fifty-four clubs were presented special certificates and subscriptions to "Today's Health" in 1963.

Medical Assistants

The Commission has worked closely with the Wisconsin State Medical Assistants Society during the past year, and one member is an advisor to their national organization. As this organization strives to improve the educational level and job efficiency of its members, it deserves the support of individual physicians and medical societies. The Commission recommends that information on medical assistant courses offered by the vocational and adult schools in the state be communicated to physicians to aid them in advising young people interested in this health career.

Oral Polio Vaccine

While the Commission has not been directly involved in the program of immunizing Wisconsin residents against poliomyelitis by use of the Sabin oral vaccine, it feels that comment is appropriate. This preventive health measure has had a major secondary benefit in the public relations programs of county medical societies and the medical profession as a whole. As this report is written, the Commission has record of immunization programs being conducted in 58 of Wisconsin's 72 counties, with a high percentage of the residents being immunized in most counties. In addition, numerous Wisconsin residents are receiving the vaccine from their family physicians. The cooperative efforts with paramedical personnel and community organizations, with the attendant publicity, are invaluable in portraying the physician and his medical society to the public.

County Society Representatives

As the Commission develops its programs, it sees a need for more effective liaison with the county medical societies. It, therefore, urges each county society to appoint one member, preferably the

SCIENTIFIC EXHIBIT: THIRD PLACE—Smaller Hospitals and Individuals. "Power Lawn Mower Injuries" by Drs. J. T. Sullivan, Jr. and J. S. Kretchman, St. Joseph's Hospital, Milwaukee.

chairman of its public relations committee, to serve as the local contact for the Commission concerning state level planning and as a recipient of information concerning materials and resources available at the state level for use in local public relations programs.

REPORT OF COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION—MAY, 1964

George B. Murphy, Jr., M.D., La Crosse, Chairman
M. V. Overman, M.D., Neillsville
P. C. Dietz, M.D., La Crosse
H. G. Bayley, M.D., Beaver Dam
A. J. Richtsmeier, M.D., Madison
C. J. Picard, M.D., Superior
T. H. McDonell, M.D., Waukesha
Edgar End, M.D., Milwaukee
S. L. Henke, M.D., Eau Claire
J. S. Hirschboeck, M.D., Milwaukee

The Commission on Hospital Relations and Medical Education of the State Medical Society of Wisconsin wishes to report activities in the two major areas assigned to its jurisdiction: that of relationships with hospitals and their medical staffs and the ever-present subject of medical education and the furtherance of its efforts and goals.

The Commission commends its legal counsel for the development of "Physicians' Guidelines for Delegation of Duties and Functions to Nurses" which was printed in the January, 1963 issue of the *Wisconsin Medical Journal*. This statement outlines in general terms functions which lawfully may be delegated to nurses and functions which must be performed under the direction and supervision or upon prescription of the physician.

The Commission has reviewed several bylaws of medical staffs submitted to it and has consulted in person with one county medical society relative to its desire to establish uniform bylaws of medical staffs of hospitals within its jurisdiction.

The Commission has considered several questions with respect to interpretation of the guidelines of delegation of duties to nurses and has submitted the appropriate advice.

The Commission has reviewed the policy concerning dentists submitted by the Joint Commission on Accreditation of Hospitals, educational programs in nursing and has apprised itself of the current status of regional hospital planning councils. The only hospital council which has engaged in planning in Wisconsin to date is a recently established Milwaukee area hospital planning council. This organization is presently seeking Federal support for its initiation and will be underway with a permanent director and staff on July 1, 1964. Hospitals in the greater Milwaukee area have indicated staunch approval as has industry and the Milwaukee County Planning Council.

The Commission has reviewed the situation of the medical student who is employed as an "extern," "clinical clerk," or other title, to work with established groups of physicians to further his educational opportunities.

The Commission has met with representatives of the University of Wisconsin Medical School and Marquette University School of Medicine to review the program of externships, preceptorships which exist in those institutions.

The Commission is currently engaged in the project of preparation of a statement together with the Wisconsin Hospital Association, which will point-up the problem of the difficulty facing many small hospitals and others in providing medical care for patients who present themselves to hospital emergency rooms for care.

The Commission believes the matter of medical education is of prime importance.

The Commission believes, further, continued liaison with the two Schools of Medicine in Wisconsin will bring the support not only of its membership, but that of the Society which it represents in furthering the necessity of providing top-notch candidates for admission.

The Commission hopes, on a selective basis, to renew its Community Achievement Award Program to hospitals which in the opinion of local medical staffs warrant such recognition. While this program cannot be routine, the Commission believes it will be important to acknowledge the true achievements of cooperation and working together of administration, medical staff and Board of Trustees providing good patient care.

The Commission believes the Council and the House of Delegates will be interested to know of its sincere interest in the projects which have been assigned, and it stands ready to accept advice and counsel of the Council and House of Delegates.

REPORT OF COMMITTEE ON CANCER—MAY, 1964

G. I. Uhrich, M.D., La Crosse, Chairman
G. A. Smiley, M.D., Delavan, Vice-chairman
J. W. Boren, Jr., M.D., Marinette
M. W. Stuessy, M.D., Brodhead
G. H. Williams, M.D., Marshfield
R. C. Frank, M.D., Eau Claire
R. C. Glise, M.D., Richland Center
J. J. Gramling, Jr., M.D., Milwaukee
J. F. Brown, M.D., Rhinelander
W. H. Reed, M.D., Watertown
J. E. Dettmann, M.D., Green Bay
John G. Telford, M.D., Washburn
J. R. Hoon, M.D., Sheboygan

The Committee on Cancer wishes to report a recommendation to the Council that it approve "local cancer information service operations" believing the potential value and public health effects of this service are beneficial to the public welfare.

The Committee on Cancer recommends adoption of a resolution regarding cigarette smoking and lung cancer, which is attached to this report. (Resolution No. 23)

The Committee on Cancer believes the Cytology Service Program of the State Laboratory of Hygiene must be integrated with private similar programs which are available to persons throughout Wisconsin. The Committee urges the Council to recommend to the House of Delegates that a program of information with respect to the importance of current and proposed cytology programs for females beyond the age of 20 years be disseminated widely among the citizens of Wisconsin.

The Committee on Cancer believes that some beneficial results may be obtained by the reactivation of the Coordinating Committee on Cancer, and pending further information, recommends to the Council and to the House of Delegates that the Cancer Coordinating Committee be held in abeyance, but not be disbanded, pending assignments to it.

With respect to United Health Foundations, Inc., the Committee believes the research and treatment programs which have been initiated and recommended by the American Cancer Society and other bona fide national voluntary health agencies should be emphasized and continued as the more scientific and practical way to combat diseases rather than a non-specific approach to illnesses of the whole man.

RESOLUTION NO. 23

WHEREAS, the preponderance of scientific evidence strongly indicates a causal relationship between cigarette smoking and such diseases as cancer of the lung, cardiovascular disorders, pulmonary emphysema, chronic bronchitis and others; and

WHEREAS, the compilation of scientific research by the United States Department of Health Education and Welfare has resulted in direct conclusions supporting this statement as contained in the report issued by the Surgeon General of the United States; therefore, be it

Resolved, that the State Medical Society of Wisconsin urge physicians to engage in an intensified educational program directed to the public in general and to youth in particular relative to the health hazards of smoking;

Resolved, that the State Medical Society of Wisconsin delegates to the American Medical Association be instructed to introduce this resolution and urge its endorsement by the American Medical Association House of Delegates in June, 1964.

■ REPORT OF MENOMINEE COUNTY STUDY COMMITTEE OF THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION—MAY, 1964

Glen J. Stuesser, M.D., Madison, Chairman
Patricia Lanier, M.D., Kewaunee
E. P. Rahde, M.D., Galesville
E. R. Krueger, M.D., Hayward
George Nadeau, M.D., Green Bay
H. F. Laufenburg, M.D., Shawano

The Menominee County Study Committee of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin has held four meetings since its last report to the Council which was contained in the Annual Report of the Foundation and submitted in May of 1963.

Much of the work of the Committee has been devoted to the planning of the Operation Health Guard project. The purpose of this project is twofold:

1. To gather significant data concerning the actual health needs of the residents of Menominee County in terms of health practices, care and services, so that future planning for medical, hospital and public health services in the County may be given a factual basis.
2. To provide sound, basic health care counseling to the residents of Menominee County.

A nurse-educator, Miss Martha Jenny, R.N., who holds a degree in Public Health Nursing, has been selected to carry out the project. She is working with the Menominee County Nurse and will be collaborating with the District Health Officer, whose headquarters are in Green Bay.

Liaison is being maintained with Miss Jenny and this Committee through Herbert F. Laufenberg, M.D., who conducts his medical practice in Shawano, Wisconsin, which adjoins Menominee County.

The project began on February 17, 1964 and will be completed on August 15, 1964.

Miss Jenny is working closely with the County Welfare Director, the County Nurse and other county officials. She will be receiving valuable background information from a wide variety of sources including the Shawano County Medical Society, Langlade County Medical Society, hospitals in Shawano and Antigo, as well as the Welfare Departments of surrounding counties.

Miss Jenny will, in addition, utilize resource material available from the University of Wisconsin Department of Sociology, the State Board of Health, the Attorney General's Office, and other departments which in the past have been interested in the health and environment of the residents of the County. Several independent studies have been prepared which include some of the factors involved in the current study which will be invaluable in this project.

During a recent meeting of the Committee with the County Board held in Keshena, Wisconsin, the county seat, it was evident that the County Board and other county officials are intensely interested in this project and will lend their cooperation and assistance to it.

Other efforts of the Committee have been to assist the Menominee Enterprises, Inc., in its quest for a resident physician. While a news item appeared in the AMA News concerning the need for a physician in Menominee County in July, 1963, and while there were several responses indicating interest, to date no physician has been acquired who will serve the residents of Menominee County with the establishment of his headquarters in the County.

The most recent task of the Committee has been to establish within the general frame work of the Foundation, a scholarship program specified to be used to provide opportunities for younger residents of Menominee County to attain skills and efficiencies in health careers through appropriate education resources.

Currently several awards are under consideration and one has been made to a resident of Menominee County to pursue a course of practical nurse training under the auspices of a donor who has been most enthusiastic about this fellowship program.

It is believed by the establishment and use of such scholarship moneys, Menominee County residents may themselves supply candidates who will return to the County to offer many of the health services which are presently so vitally needed.

COUNCIL AWARD. Dr. Francis J. L. Blasingame (left), executive vice-president of the American Medical Association, was presented the Council Award by the Council chairman, Dr. James C. Fax, La Crosse (right), at the Society's annual dinner Tuesday evening, May 12. The Society's highest honor is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

ANNUAL DINNER. A capacity crowd at the annual dinner on Tuesday evening, May 12, heard Dr. F. J. L. Blasingame speak on the topic "Of Tomorrow." He is executive vice-president of the American Medical Association; he was also presented with the Council Award that evening. Society members and their guests enjoyed President Egan's reception before dinner and dancing later. Members of the Fifty Year Club were also presented.

■ NECROLOGY REPORT—MAY 1964

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated in italic.

H. A. Aageson, M. D., Oconto
Ulrich Senn, M. D., Milwaukee
H. C. Marsh, M. D., Shawano
J. B. MacLaren, M. D., Milwaukee
W. O. Sydow, M. D., Wauwatosa
A. M. Bodden, M. D., Milwaukee
E. A. Waldeck, M. D., Milwaukee
C. K. Schubert, M. D., Madison
B. Radich, M. D., Winnebago
E. F. Peterson, M. D., Wauwatosa
V. J. Guzzetta, M. D., Milwaukee
W. J. Allen, M. D., Beloit
H. P. Maxwell, M. D., Milwaukee
R. S. Vivian, M. D., Beloit
J. C. Harman, M. D., La Crosse
D. M. Daley, M. D., La Crosse
M. Trautmann, M. D., Prairie du Sac
C. T. Droege, M. D., Superior
G. R. Reay, M. D., Onalaska
A. L. Mayfield, M. D., Kenosha
M. M. Spitz, M. D., Milwaukee
W. H. Bayer, M. D., Merrill
G. W. Bartels, M. D., Janesville
S. M. B. Smith, M. D., Wausau
C. B. Slotnik, M. D., Milwaukee
L. G. Langlois, M. D., Milwaukee
T. E. Kendall, M. D., St. Louis, Mo.
W. J. Clothier, M. D., Waukesha
R. M. Rogers, M. D., Milwaukee
G. B. Wiles, M. D., Sheboygan
K. J. Denys, M. D., Green Bay
J. O. Muehlhauser, M. D., Sturgeon Bay
L. S. Shemanski, M. D., Wautoma
C. O. Lindberg, M. D., Grantsburg
H. G. Pudleiner, M. D., Algoma
E. E. Flemming, M. D., Wausau
J. W. O'Neill, M. D., Mercury, Nev.
B. H. Dike, M. D., Owen
E. M. Paine, M. D., Wauwatosa
J. P. Pauly, M. D., La Crosse
H. M. Guilford, M. D., Madison
E. F. Pischke, M. D., Baraboo
H. H. Prudowsky, M. D., Milwaukee
H. W. Hefke, M. D., Milwaukee
R. C. Thompson, M. D., St. Croix Falls
H. G. Decker, M. D., Milwaukee
O. S. Orth, M. D., Madison
H. Trautmann, M. D., Scottsdale, Ariz.
J. R. Hanson, M. D., Everett, Wash.
May R. Wells, M. D., Belleville, Ill.
C. L. White, M. D., Mineral Point
D. H. Witte, M. D., Milwaukee
R. H. Gray, M. D., Onalaska
C. A. Hultman, M. D., Helena, Montana
G. W. Leitch, M. D., Milwaukee
V. W. Rapp, M. D., Sheridan, Wyoming
J. H. Fowler, M. D., Lancaster
Annette C. Washburne, M. D., Madison
J. L. Garvey, M. D., Milwaukee
P. E. Oberbreckling, M. D., Milwaukee
Otto F. Dierker, M. D., Youngstown, Ariz.

■ MEMBERSHIP REPORT

(For the year ending December 31, 1963)

Members paying no dues		186	
Affiliate members	66		
Military service members	48		
Honorary members	9		
Life members	59		
Special service	4		
Total	186		
Members paying pro rata dues (military service returned and new after July 1)		50	
Associate members		77	
Members in residency training		170	
Members paying full dues		3381	
Educational members		20	
Total		3698	
Total membership			3884

MEMBERSHIP REPORT

State Medical Society of Wisconsin
TOTAL MEMBERSHIP BY COUNTY
DECEMBER 31, 1963

County Society	Regular	Resident	Associate	Affiliate	Life	Military	Honorary	Educational	Special Service	Career Appointment	Total
Ashland-Bayfield-Iron	18		1		1						20
Barron-Washburn-Sawyer-Burnett	32	1		1		1					35
Brown	121		1		1	1					124
Calumet	7										7
Chippewa	25										25
Clark	13	1									14
Columbia-Marquette-Adams	28	1	2	1							32
Crawford	8										8
Dane	365	40	13	5	2	14	3	12	1	9	464
Dodge	42	2	1	1							46
Door-Kewaunee	21										21
Douglas	22			1							23
Eau Claire-Dunn-Pepin	78	2	3	2	3						88
Fond du Lac	67	2	1		3	1					74
Forest	4			1							5
Grant	28		2		1						31
Green	34	1	1	1	1						38
Green Lake-Waushara	15	1			1						17
Iowa	9			1	2						12
Jefferson	29	3	2		1						35
Juneau	5										5
Kenosha	71		3	3					1		78
La Crosse	92	1	1	7	2						103
Lafayette	7			2		1					10
Langlade	13			1	1						15
Lincoln	14		2		1						17
Manitowoc	45				1						46
Marathon	64			2	1	1					68
Marinette-Florence	16	1	1								18
Milwaukee	1173	96	24	23	16	21	5	8	2	6	1374
Monroe	14				1						15
Oconto	8	1									9
Oneida-Vilas	24		2	1							27
Outagamie	88	1	2		2						93
Ozaukee	17										17
Pierce-St. Croix	29	1	1		1	1				1	34
Polk	21	3									24
Portage	26										26
Price-Taylor	10					1					11
Racine	114			6	4	1	1				126
Richland	12	1									13
Rock	103	1	4	2	5						115
Rusk	5										5
Sauk	20	1	1	2							24
Shawano	16	1									17
Sheboygan	71		3		2						76
Trempealeau-Jackson-Buffalo	21	2	2								25
Vernon	16		1								17
Walworth	27					1					28
Washington	24	1	1	1	1						28
Waukesha	97	4	1	1	1	3					107
Waupaca	21	1									22
Winnebago	88		1	1	3	1					94
Wood	77				1						78
TOTALS	3415	170	77	66	59	48	9	20	4	16	3884

■ REPORT OF SURVEY STUDY COMMITTEE —MAY, 1964

J. C. Griffith, M.D., Milwaukee, Chairman
R. P. Sproule, M.D., Milwaukee
G. F. Tegtmeyer, M.D., Milwaukee
C. J. Picard, M.D., Superior
L. W. Schrank, M.D., Waupun
P. B. Mason, M.D., Sheboygan
J. H. Houghton, M.D., Wisconsin Rapids
Ex officio
W. J. Egan, M.D., Milwaukee
R. E. Callan, M.D., Milwaukee
H. W. Carey, M.D., Lancaster

The Survey Study Committee submits to the House of Delegates these resolutions resulting from further study and review of the Program and Management Survey Report. In addition the Committee submits as directed a "more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans."

It is impossible in a task of this magnitude to incorporate into these resolutions lengthy preambles in detail supporting the Committee's conclusions. It therefore will be advisable for each member of the House of Delegates to use his copy of the B.A.H. report while considering the resolutions. Appropriate page and paragraph reference to the B.A.H. report is noted on each resolution.

These resolutions are not official until acted on by the House of Delegates of the State Medical Society.

The previous recommendations that you received in November 1963 were in the nature of a preliminary proposed partial report. These recommendations are now superseded by the enclosed resolutions.

Part Four of the Booz, Allen and Hamilton report entitled "The Insurance Programs," pages 179 to 220, should be thoroughly reviewed as preliminary preparation to considering the Committee's analysis of the Blue Plans.

Analysis of Booz-Allen-Hamilton Report Dealing with Reorganization of Blue Shield Plans

The October 1963 meeting of the House of Delegates directed your survey committee to prepare a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Shield plans for submission to this House of Delegates.

Your committee studied in detail all aspects of the survey, pages 180 to 191 of the report, together with the eight alternatives for reorganization, pages 192 to 208, which it recommends for study by all the membership. In addition it reviewed the history, background, and controversies between the two plans.

It is recognized that while the two plans have the same purpose, there is a difference in philosophy in their origin. Surgical Care was geared to serve a metropolitan area, but in recent years has been sold and accepted throughout a large portion of the State.

Wisconsin Physicians Service, being a part of the State Medical Society, has felt it a duty to provide hospital, pharmaceutical and dental coverage, to explore experimental plans, and to bring its service to rural and sparsely populated areas. Both have attempted to meet the requirements of the senior citizen but need to do much more.

The interviews and questionnaires on which the report was based show that a large percentage of Wisconsin physicians favored some change and reorganization and that a majority of those responding favored a merger of the two into one statewide plan.

According to the B.A.H. report, economy of administration appears to be a reason for a merger. If a merger would succeed as well as might be hoped for and survive a difficult period of reorganization, there might be a reduction in administrative expense.

There would be the convenience of filling out only one type of report, but the forms as they exist are at least as brief and convenient as those of the private insurance companies.

Elimination of competition in sales is considered as a reason for merger but it must also be considered that this competition has contributed to a progressive improvement in benefits to the subscriber in the contracts of both plans.

Overcoming a focal point of discord between the Milwaukee County and State Medical Societies was undoubtedly a major reason for the opinions as expressed in the questionnaires, but this is questionable when the difficulties that would accompany an attempted merger are considered.

Merger of the two Wisconsin Blue Shield Plans operated by a separate corporation controlled equally by the State Society and the Milwaukee County Society, and including lay representation and cooperating with Wisconsin Blue Cross under an agency agreement, appears to be the most ideal plan according to the B.A.H. report.

To effect a merger it is first necessary to have a willingness to merge on the part of all the parties concerned. The House of Delegates does not have the authority to our knowledge to order Milwaukee Surgical Care to merge with the Wisconsin Physicians Service because Surgical Care has separate authorization under enabling legislation of the Wisconsin Statutes.

Representatives of Milwaukee County Medical Society have through an ad hoc committee of its Board of Directors stated, however, that in their opinion Surgical Care would be willing to consider merger providing Wisconsin Physicians Service would return to the status of that immediately previous to 1958 before WPS separated from Blue Cross, and providing also that Milwaukee County have its just representation in a merged plan.

In the opinion of the Executive Committee of the Commission on Medical Care Plans, WPS recognizes no unreserved conviction on the part of all the parties concerned that a merger and agency agreement are desired by each of them, and secondly, an equally important consideration is that there be indisputable evidence that such a merger and such an agency agreement would in fact be in the public interest. The report and recommendations of B.A.H. fail completely to support the contention that a merger would solve the basic problems which contributed in part to authorizing the management study. But even more important, not a single fact or figure cited in the report deals specifically and precisely with how the public would be benefited either by the merger of the two Blue Plans or by entering into an agency agreement with Blue Cross of Wisconsin.

It is the firm belief of the Executive Committee of WPS that the merger of the two Blue Shield plans, independent of the question of an agency agreement with Blue Cross, would remove an element of competition which is unquestionably in the public good, when that competition is in all respects ethical and the parties to it are accurately identified. It is convinced beyond all reasonable doubt that no segment of the public should be deprived by merger or otherwise of the free choice of an insurance carrier which is properly and profitably theirs in the competitive market place.

Associated Hospital Service, Inc., Blue Cross of Wisconsin, through its president, states that they have always been willing to give careful consideration to any specific proposal of agency relationship that would be in the public interest. They consider their current relationship with the Surgical Care Blue Shield plan to be most satisfactory. Through this agency relationship they have been able to effect many significant administrative economies and the cooperative spirit and interest of Surgical Care has, in their judgment, made it possible to provide the people of Wisconsin with the finest combination of health insurance plans in a most efficient and economical manner. Since they consider the public interest to be the major interest involved, they believe it reasonable to state that any specific proposal for a change in their current arrangement would have to at least equal, if not exceed, the results that now accrue to the public through their agency relationship with Surgical Care.

The two Blue Shield plans are now operating successfully. Surgical Care since its inception in 1943 has accumulated a reserve of about five million dollars. WPS, established in 1946, has approximately two and ½ million dollars in reserves. To establish one statewide plan would undoubtedly present difficulties in this regard.

The two Blue Shield plans are at the present time operating harmoniously and are cooperating in many areas. There is less discord between the physicians of Milwaukee County and the physicians of the State of Wisconsin than there has been for many years. To establish a merged plan would necessitate a change in the entire organization of the State and Milwaukee County Medical Societies. Such change and the process of obtaining approval would result in considerable debate and controversy, open old wounds, again divide the physicians of Wisconsin, and interfere with our public responsibility of helping our patients to pay their bills for medical care without government entrance into the health insurance field.

The resolution that the House of Delegates passed at its October 1963 meeting provided that Wisconsin Physicians Service and Surgical Care continue to operate independently under their present structure and that each operate throughout the state under

fair competition. It was not the intent of your survey committee at that time nor is it now to close the door on eventual merger of the Blue Shield Plans.

■ RESOLUTIONS—MAY, 1964

RESOLUTION NO. 1

Resolved, That the House of Delegates is in accord with Parts One and Two of the Booz-Allen-Hamilton report as they describe the philosophy, objectives, programs and services of the State Society and that future programs be directed to the changing needs of the physician and the medical profession; and be it further

Resolved, That the programs and services of the Society should be developed continuously to meet varying needs throughout the state and that new programs should be added as needed to the Society's already expanded scope of activities.

Reference—BAH Report, Page 225, Part One, Section 5
Part Two—Sections 5 and 6
Page 226, Section 7 only
Page 10, 20, 21

RESOLUTION NO. 2

Field Services

Resolved, That the Field Services staff and activities should continue to operate but the program be kept under review; and be it further

Resolved, That a detailed report shall be submitted by the Council to the House of Delegates at the 1964 interim meeting, covering the Field Services' scope of activities and cost analysis.

Reference—BAH Report, Page 226, Section 7(1) only
Page 22

RESOLUTION NO. 3

Assistance to County Medical Societies

Resolved, That the State Medical Society continue to aid the component societies and render those services that are practical and reasonable, (see Appendix 1) and that the State Medical Society and its component societies should make full use of the programs and materials supplied by the American Medical Association.

Reference—BAH Report, Page 226, Section 7(2) only
Page 23

RESOLUTION NO. 4

Relationship With Other Professional Groups

Resolved, That the State Medical Society shall continue to maintain a strong relationship with other professional groups; stimulate new public educational programs; continue to study the relationship of management and labor to urban and rural health problems, and to study the medical aspects of social disorganization and health care; and appoint special committees to study these problems as the occasions arise.

Reference—BAH Report, Page 227, Section 7(3)(4)(5)
Pages 24, 25, 26

RESOLUTION NO. 5

Community Health Programs

Resolved, That commendation is due the staff of the State Medical Society for the many excellent guides and brochures pertaining to the State Society, (see Appendix 1) and the many excellent statewide programs.

Reference—BAH Report, Page 227, Section 7(6)
Page 26, 27

RESOLUTION NO. 6

Physician Education Programs in Non-Medical Aspects of Practice

Resolved, That the Society shall continue to sponsor additional physician education programs that stress socio-economic aspects of medicine.

Reference—BAH Report, Page 227, Section 7(7)
Pages 27, 28 for further explanation

RESOLUTION NO. 7

Program Appraisals and Membership Surveys

Resolved, That the Society shall continue to conduct regular program appraisals and membership surveys.

Reference—BAH Report, Page 227, Section 7(9)
Pages 30, 31

RESOLUTION NO. 8

Tenure of Delegates

Resolved, That the House of Delegates recommends to the component county societies and the Scientific Sections that the terms of delegates and alternate delegates to the State Medical Society be no less than two calendar years, and that where a society is entitled to more than one delegate, so nearly as possible an equal number shall expire each year, and the number of terms allowed shall be left to local discretion; and be it further

Resolved, That Section 8, Chapter XI of the Bylaws, be amended to provide that the minimum term of delegates shall be for two calendar years.

Reference—BAH Report, Page 228, Section 4(3)
Pages 44, 45

RESOLUTION NO. 9

Scientific Sections

Resolved, That the Scientific Sections in the House of Delegates continue with their present structure pending further study by the ad hoc committees of the State Society and the AMA.

Reference—BAH Report, Page 228, Section 4(5)
Page 47

RESOLUTION NO. 10

Duties of Delegates

WHEREAS, Delegates should maintain strong relationships with their component societies; now therefore be it

(1) *Resolved*, That the administrative staff of the State Society send to each elected delegate and alternate delegate a copy of the following duties upon certification of these delegates and alternate delegates; and be it further

(2) *Resolved*, That at a meeting of every county society called after the district caucus and before the Annual Meeting of the House of Delegates, each delegate (or a representative of the delegation from larger societies) should explain to the county society membership every matter of importance which will be acted on at the Annual Meeting, and he also should seek and appraise the opinions of the members on these issues; and be it further

(3) *Resolved*, That following all meetings, delegates shall prepare and deliver to an early meeting of each county society a concise report of actions taken at the meeting, and they should also indicate the nature and extent of their participation in these actions and decisions; and be it further

(4) *Resolved*, That during the year, delegates should determine the needs of the membership in each county society and should keep aware of developments in the State Society and Council, and be it further

(5) *Resolved*, That the House of Delegates recommends that each component county society include these recommended duties of delegates in their county society constitution and bylaws.

Reference—BAH Report, Pages 228–229, Section 4(7)
Pages 50, 51

RESOLUTION NO. 11

Resolved, That the presiding officer and the secretary shall distribute to delegates and alternate delegates a digest of all actions taken at the House of Delegates meetings as soon as possible after each meeting.

Reference—BAH Report, Page 229, Section 4(7) paragraph 3
Pages 50, 51

RESOLUTION NO. 12

Reference Committees

Resolved, That the Reference Committees shall continue to be appointed by the Speaker, at least two months before the date of the meetings, and that the membership of each committee continue to be reasonably representative geographically, and that at least three weeks in advance of the meetings, members of the Reference Committee receive comprehensive information relating to all matters to come before their committee insofar as this can be determined at that time.

Reference—BAH Report, Page 229, Section 4(8)
Page 51

RESOLUTION NO. 13

Candidates for Councilor

WHEREAS, Experience of other societies which provide for nomination and election of councilors by the membership of each councilor district has been disappointing in that this method often fostered factionalism rather than better "grass roots" membership participation; and

WHEREAS, The present method of nomination of councilors only by the respective councilor district delegates (and not as erroneously reported in the BAH report on page 55 that "At present delegates may participate in the nomination of councilors from districts other than their own") and the election of the councilors by a majority of the votes cast by the House of Delegates has been generally satisfactory in the past; now therefore be it

Resolved, That the present method of nominating and electing councilors be retained.

Reference—BAH Report, Page 229, Section 5(2)
Page 55

RESOLUTION NO. 14

Councilor Terms and Limitations

Resolved, That no individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and that no more than a total of six terms of service as councilor shall be permitted; and be it further

Resolved, That the above provision be inserted in Section 2, Article IX, of the Constitution.

Reference—BAH Report, Page 230, Section 5(3)

RESOLUTION NO. 15

Resolved, That appointments to State Medical Society Council committees be made by the Chairman of the Council with the consent of the Council.

Disaster Medical Care
Editorial Board
Military Medical Service
Health Economics of American Life (HEAL)
Commission on Medical Care Plans
Committee on Clinical Medicine

Reference—BAH Report, Page 230, Section 5(3)
Page 56

RESOLUTION NO. 16

Procedures to Improve Council Meetings

Resolved, That the House of Delegates recommends to the Council that the following procedures be adopted in order to increase the effectiveness of Council meetings:

That at least three weeks before each meeting, the Chairman of the Council, with advice from the Secretary, shall establish an agenda which should clearly list all matters to be considered at the meeting in the sequence in which they are to be considred, with an estimate of the amount of time needed for each item, and at this time also, it should be determined by the Chairman of the Council which staff members, advisers, or other persons should be in attendance at the meeting;

That at least two weeks prior to each meeting, (except the meeting following the annual meeting of the Society) each councilor should receive the agenda and information which will assist him in dealing with issues to come before the Council;

That included in the information sent to councilors should be brief staff papers on issues of special significance on which the Council is expected to act, with each such paper wherever possible containing the following elements: (1) a statement of the issue, problem, or question, (2) pertinent facts (3) summary statements in support of and against alternative actions, and (4) staff recommendations;

That all material prepared for the Council should be marked "action required," "for information only," or "long-range planning," so that councilors will be able to allocate their reading time effectively;

That at each meeting, staff members should be prepared to discuss matters covered in the above papers if and as requested by the Council;

That within two weeks after each Council meeting, each councilor, officer and AMA delegates should receive draft minutes of the previous meeting, approved by the Chairman of the Council;

That at each Council meeting, final approval should be given to minutes of the previous meeting;

That all councilors should receive brief minutes of each meeting of each Council committee, approved by the Chairman, within two weeks following the meeting.

Fiscal note: The committee is advised by the staff that the additional cost of these routines will involve a minimum of $7,500.

Reference—BAH Report, Page 231, Section 5(8)
Pages 62, 63

RESOLUTION NO. 17

Selection of Officers

WHEREAS, Election of officers by popular vote of the membership would tend to deter many capable leaders from entering into competition with their colleagues, therefore be it

Resolved, That the present method of selection of officers shall be retained.

Reference—BAH Report, Page 234
Pages 70, 71, 72

RESOLUTION NO. 18

WHEREAS, The roles of Society officers should be clarified; now therefore be it

Resolved, That the President shall be the official spokesman of the Society;

That the President should carry out the ambassadorial function between Wisconsin physicians and those in other states;

That the President of the State Society should provide vigorous leadership in developing and supporting policies and objectives;

That the President should make appraisals of matters which the Council, occupied to a considerable degree with the month-to-month activities of the Society, does not have the opportunity to study, and he should advise on trends, long-term changes, and possible new developments;

That the President, when he feels it useful and with approval of the Council should appoint ad hoc committees to study various aspects of the Society such as organization, program, services, or administration;

That the President should bring to the Council a current perspective on how the Society is viewed by different groups, and in what areas improvements seem most needed; and finally

That the President also should present to the membership the problems facing the profession and the policies and program alternatives and actions he advocates.

Reference—BAH Report, Page 234, Sections 6, 6(3), 6(3.1)
Pages 72, 73, 74

RESOLUTION NO. 19

Resolved, That the President-Elect should assist the President and, in the process, crystallize his understanding of the needs of the medical profession in addition to those duties listed in the bylaws.

Reference—BAH Report, Page 234, Section 6(3.2)
Pages 74, 75

RESOLUTION NO. 20

Resolved, That the Speaker and Vice Speaker shall be responsible for the effective functioning of the House of Delegates.

Reference—BAH Report, Page 234, Section 6(3.3)
Page 75

Preamble to Resolutions 21 and 22

WHEREAS, The Survey Study Committee recommends that increased effort should be made to strengthen the relations between academic and practicing physicians, and

WHEREAS, Medicine's prime responsibility is improvement of the quality of medical care and practice, to which every segment of the profession, research, education, administration and practice, directs its full effort, and

WHEREAS, The post-war scientific revolution and the socio-economic changes affecting medical practice have resulted in significant changes from the traditional pattern of medicine, and

WHEREAS, The greatly increased emphasis in medical research and the changes in methodology in medical education are resulting in increased full-time physician participation in these fields of medicine, and

WHEREAS, There is increasingly less opportunity for communication and understanding between these new dominant disciplines in medicine, although the prime objective of each remains unchanged—improvement of the quality of medical practice;

The Survey Study Committee therefore presents the following resolutions to the House of Delegates as a practical beginning in strengthening relations between academic and practicing physicians:

Reference—BAH Report, Page 227, Section 7(8)
Page 29 and 30

RESOLUTION NO. 21

WHEREAS, The State Medical Society of Wisconsin can benefit from the participation of many non-member physicians in the Society's scientific programs; and

WHEREAS, The present restrictions serve mainly to alienate academic physicians at a time when the society should make every effort to gain their confidence and membership; now therefore be it

Resolved, That the existing restrictions on participation of non-society members in society programs be eliminated.

Reference—BAH Report, Page 227, Section 7(8)

RESOLUTION NO. 22

WHEREAS, Lack of communication and resulting misunderstanding are responsible for many of the so-called Town-Gown problems; and

WHEREAS, Symposiums on Town-Gown would be an excellent initial means to promote communication and understanding between academic and practicing physicians in Wisconsin; now therefore be it

Resolved, That the State Medical Society of Wisconsin conduct one-day symposiums in Madison and Milwaukee on Town-Gown inviting all responsible and interested parties to participate.

Fiscal note:

One meeting in Milwaukee:	
Attendance about 75 out of 100	
Use club facilities	
Lunch and preprandial (including room charge)	$ 375.00
Out-of-state speaker, honorarium and expense	125.00
Staff time in total about one week, including correspondence, arrangements, keeping minutes of meeting, and travel	175.00
	$ 675.00
One meeting in Madison:	
Attendance about the same	
Use SMS facilities	
Lunch and preprandial @ $2.75	$ 206.75
Kitchen extra time and maintenance cleanup	15.00
Out-of-state speaker	125.00
Staff time about the same as for Milwaukee	150.00
	$ 496.75
Attendance of Councilors and Officers and possibly a few representing committees—travel and overnight expense and meeting expense associated with planning	$ 250.00
Total estimated budget including miscellaneous expense	$1,500.00

Reference—BAH Report, Page 227, Section 7(8)

(Resolution No. 23 appears with Menominee County Study Committee Report.)

RESOLUTION NO. 24

Introduced by the Manitowoc County Medical Society

Resolved, That the State Medical Society of Wisconsin require the bylaws of the hospital staffs of all hospitals located in the State of Wisconsin, upon the staff of which are members of the State Medical Society, contain a provision in the bylaws of the staff of each hospital providing that before an appointment to the staff of said hospital is denied, revoked, withdrawn, suspended, cancelled or not renewed, that said physician or surgeon be given the right of hearing prior to said action, and to be represented by counsel or any other representative of his own choosing thereat; that said physician or surgeon be given reasonable written notice of the time of said hearing.

SCIENTIFIC EXHIBIT. THIRD PLACE—Larger Hospitals. "The Configuration of Abdominal Parietes," by Drs. R. S. Monk, S. D. Willson, L. C. Corey, Marquette University School of Medicine, Milwaukee.

RESOLUTION NO. 25

Introduced by the Waupaca County Medical Society

Resolved, That the State Medical Society of Wisconsin recommends that persons taking advantage of the Mobile Chest X-ray Unit, Blood Sugar and Blood Pressure check, sign an authorization for examination and that the person fully understands his obligation for the follow-up exam required or requested by the State, and that the expense of the follow-up examination is to be borne by the patient.

RESOLUTION NO. 26

Introduced by: Reference Committee on Resolutions, October 1963

Resolved, That Chapter III, Section 1, of the Bylaws be amended by adding the same sentence used by the AMA: "The House of Delegates shall hold one interim session each year."

RESOLUTION NO. 27

Introduced by: The Council, October 1963

Resolved, That Chapter VIII of the Bylaws be amended to create a new Section 6, renumbering present Sections 6 and 7:

"Section 6. Scientific Fellows. The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

"By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification."

Comment: This would extend the privileges of membership to *non-M.D.* teachers of the basic sciences, by Council election. They would have the right to attend meetings of the Society and to receive the Wisconsin Medical Journal, but no right to vote or hold office. The fiscal impact of this amendment would be measured by the number conferred times the subscription rate for the WMJ at $6 per year.

RESOLUTION NO. 28

Introduced by: The Council, October 1963

Resolved, That Section 1 of Chapter XI of the Bylaws be amended by the addition of the following sentence:

"Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply."

Comment: This amendment has no fiscal implications.

RESOLUTION NO. 29

Introduced by: The Council, October 1963

Resolved, That Chapter VII, Section 4, of the Bylaws be amended to read as follows:

"The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

"The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities."

Comment: Because there are divisions of medicine in which the various members of the State Medical Society possess a special interest, and because of the vast amount of public policy which affects these divisions, individually as well as collectively, Chapter VII, Section 4, is amended to provide for representation from the Scientific Sections on the Commission on Public Policy. The predictable costs incurred would be those connected with meeting functions, and this would involve a nominal increase.

RESOLUTION NO. 30

Introduced by: The Council

Resolved, That Chapter VII, Sec. 2, of the Bylaws be amended as follows:

Sec. 2. The Commission on Scientific Medicine shall consist of (five) *ten* appointed members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the *scientific* affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

RESOLUTION NO. 31

Introduced by: The Council

Resolved, That the first sentence of Chapter VI, Section 1, of the Bylaws be amended as follows:

Section 1. The Council shall meet (on the day preceding) *during* the annual session, (and daily if necessary during the session) and at such other times as necessity may require, subject to the call of the chairman or on petition of three councilors.

Constitutional amendment introduced by Reference Committee on Resolutions, October 1963, for action at the Annual Meeting in May 1965:

Resolved, That Article VIII, Section 3, of the Constitution of The State Medical Society of Wisconsin be amended by striking out the present Section 3 of Article VIII and substituting the following Section:

"Section 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called."

RESOLUTION NO. 32

Introduced by: The Medical Society of Milwaukee County

Subject: Recommendations of the Survey Study Committee on the Booz, Allen & Hamilton Report

WHEREAS, The Delegation of the Medical Society of Milwaukee County met in caucus on March 9, 1964; and

WHEREAS, The Milwaukee Delegation did assiduously study the complete Booz, Allen & Hamilton Report; and

WHEREAS, The Milwaukee Delegation did analyse and review the recommendations of the Survey Study Committee on the Booz, Allen & Hamilton Report proposed for the May, 1964 House of Delegates; now therefore, be it

Resolved, That the Delegation of The Medical Society of Milwaukee County urges the House of Delegates to implement the following recommendations of the Survey Study Committee on the Booz, Allen & Hamilton Report:

1. Page 225 PARTS ONE AND TWO

   Your Committee is in accord with Parts One and Two of the report as they describe the philosophy, objectives, programs and services of the State Society and recommends that future programs be directed to the changing needs of the physician and the medical profession. Your Committee agrees that programs and services of the Society should be developed continuously to meet varying needs throughout the state and that new programs should be added as needed to the Society's already expanded scope of activities.

   Your Committee recommends adoption of this report.

   Page 226

   7 (1) FIELD SERVICES

   Your Committee firmly recommends that the Field Services staff and activities should continue to operate, but the program be kept under review. A detailed report shall be submitted by the Council to the House of Delegates at the 1964 interim meeting, covering the Field Services' scope of activities and cost analysis.

   Your Committee recommends adoption of this portion of the report.

2. Page 226

   7 (2) ASSISTANCE TO COUNTY MEDICAL SOCIETIES

   Your Committee recommends that the State Medical Society continue to aid the component societies and render those services that are practical and reasonable, (see Appendix 1), and that the State Medical Society and its component societies should make full use of the programs and materials supplied by the American Medical Association.

   Your Committee recommends adoption of this portion of the report.

3. Page 227

   7 (3) (4) (5) RELATIONSHIP WITH OTHER PROFESSIONAL GROUPS

   Your Committee recommends that the State Medical Society continue to maintain a strong relationship with other professional groups; stimulate new public educational programs; continue to study the relationship of management and labor to urban and rural health problems, and to study the medical aspects of social disorganization and health care; and appoint special committees to study these problems as the occasions arise.

   Your Committee recommends adoption of this portion of the report.

4. Page 227

   7 (6) COMMUNITY HEALTH PROGRAM

   Your Committee commends the staff of the State Medical Society for its many excellent guides and brochures pertaining to the State Society, (see Appendix 1), and its many excellent statewide programs.

   Your Committee recommends adoption of this portion of the report.

5. Page 227

7 (7) PHYSICIAN EDUCATION PROGRAMS IN NON-MEDICAL ASPECTS OF PRACTICE

The Society should continue to sponsor additional physician education programs that stress non-medical aspects of practice.

Your Committee recommends adoption of this portion of the report.

6. Page 227

7 (9) PROGRAM APPRAISALS AND MEMBERSHIP SURVEYS

The Society should continue to conduct regular program appraisals and membership surveys.

Your Committee recommends adoption of this portion of the report.

7. Page 228

4 (3) TENURE OF DELEGATES

Your Committee recommends to the component county societies and the Scientific Sections that the terms of delegates to the State Medical Society be no less than two calendar years, and that where a society is entitled to more than one delegate, so nearly as possible an equal number shall expire each year. The number of terms allowed shall be left to local discretion.

Your Committee recommends adoption of this portion of the report.

8. Page 228

4 (5) SCIENTIFIC SECTIONS

The portion of the report dealing with voting representation of Scientific Sections in the House of Delegates was not received favorably by the Committee at this time. It therefore recommends that the Scientific Sections in the House of Delegates remain as is pending further study by the ad hoc committees of the State Society and the AMA.

Your Committee recommends adoption of this portion of the report.

9. Pages 228–229

4 (7) DUTIES OF DELEGATES

WHEREAS Delegates should maintain strong relationships with their component societies; now therefore be it

(1) *Resolved* that at a meeting of every county society called after the district caucus and before the annual meeting of the House of Delegates, each delegate (or a representative of the delegation from larger societies) should explain to the county society membership every matter of importance which will be acted on at the annual meeting. He also should seek and appraise the opinions of the members on these issues; and be it further

(2) *Resolved* that following all meetings, delegates shall prepare and deliver to an early meeting of each county society a concise report of actions taken at the meeting. They also should indicate the nature and extent of their participation in these actions and decisions; and be it further

(3) *Resolved* that during the year, delegates should determine the needs of the membership in each county society and should keep aware of developments in the State Society and Council; and be it further

(4) *Resolved* that the House of Delegates recommends that each component county society include these recommended duties of delegates in their county society constitution and bylaws; and be it further

(5) *Resolved* that the administrative staff of the State Society send to each elected delegate and alternate delegate a copy of these duties upon certification of these Delegates and Alternate Delegates.

Your Committee recommends adoption of this resolution.

10. Page 229

4 (7)
Par. 3

Delegates shall receive from the staff of the State Medical Society a digest of all actions taken at the House of Delegates meetings after approval by the presiding officer at an early date following each meeting.

Your Committee recommends adoption of this portion of the report.

11. Page 229

4 (8) REFERENCE COMMITTEES

Your Committee has reviewed the recommendations made in the report to the effect that Reference Committee members should have no other responsibilities at annual meetings. Your Committee does not agree with this recommendation because the meeting time of the Reference Committees have been changed and coordinated so that the Reference Committee members will not have to divide their time between several committees. Your Committee recommends that the Reference Committees continue to be appointed by the Speaker, at least six weeks before the date of the meetings, and that the membership of each committee continue to be reasonably representative geographically, and that at least three weeks in advance of the meeting, members of the Reference Committee receive comprehensive information relating to all matters to come before their committee insofar as this can be determined at that time.

Your Committee recommends adoption of this portion of the report.

12. Page 229

5 (2) CANDIDATES FOR COUNCILOR

Your Committee recommends that councilors be nominated and elected from each councilor district by the membership of the district at an annual meeting preceding the annual meeting of the House of Delegates.

Your Committee recommends adoption of this portion of the report.

13. Page 234

6 SELECTION OF OFFICERS

The method of selection of officers should be improved and their roles clarified. (Councilors)

6 (1) The Committee recommends that the President-Elect of the Society should not be elected by popular vote of the membership.

6 (3) The roles of Society officers should be clarified.

6 (3.1) The President shall be the official spokesman of the Society.

The President should carry out the ambassadorial function between Wisconsin physicians and those in other states.

The President of the State Society should provide vigorous leadership in developing and supporting policies and objectives.

The President should make appraisals of matters which the Council, occupied to a considerable degree with the month-to-month activities of the Society, does not have the opportunity to study. He can see and advise on trends, long-term changes, and possible new developments.

The President, when he feels it useful, should appoint ad hoc committees to study various aspects of the Society such as organization, program, services, or administration.

The President should bring to the Council a current perspective on how the Society is viewed by different groups, and in what areas improvements seem most needed.

The President also should present to the membership the problems facing the profession and the policies and program alternatives and actions he advocates.

Your Committee recommends adoption of this portion of the report.

Page 234

6 (3.2) The President-Elect should assist the President and, in the process, crystallize his understanding of the needs of the medical profession in addition to those duties listed in the Bylaws.

Your Committee recommends adoption of this portion of the report.

RESOLUTION NO. 33

Introduced by: The Medical Society of Milwaukee County

Subject: Recommendations of the Survey Study Committee on the Booz, Allen & Hamilton Report

WHEREAS, The Delegation of The Medical Society of Milwaukee County met in caucus on March 9, 1964; and

WHEREAS, The Milwaukee Delegation did assiduously study the complete Booz, Allen & Hamilton report; and

WHEREAS, The Milwaukee Delegation did analyse and review the recommendations of the Survey Study Committee on the Booz, Allen & Hamilton report proposed for the May, 1964 House of Delegates; now therefore, be it

Resolved, That the Delegation of the Medical Society of Milwaukee County urges the House of Delegates to implement the following recommendations of the Survey Study Committee on the Booz, Allen & Hamilton report:

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5 (8) PROCEDURES TO IMPROVE COUNCIL MEETINGS

Your Committee recommends that the following procedures be adopted in order to increase the effectiveness of Council meetings:

At least three weeks before each meeting, the Chairman of the Council, with advice from the Secretary, should establish an agenda. This should clearly list all matters to be considered at the meeting in the sequence in which they are to be considered. It should also estimate the amount of time needed for each item. At this time, it should be determined by the Chairman of the Council which staff members, advisers, or other persons should be in attendance at the meeting.

At least two weeks prior to each meeting, (except the meeting following the annual meeting of the Society), each councilor should receive the agenda and information which will assist him in dealing with issues to come before the Council.

Included in the information sent to councilors should be brief staff papers on issues of special significance on which the Council is expected to act. Each such paper shall wherever possible contain the following elements: (1) a statement of the issue, problem or question, (2) pertinent facts, (3) summary statements in support of and against alternative actions, and (4) staff recommendations.

All material prepared for the Council should be marked "action required," "for information only," or "long range planning," so that councilors will be able to allocate their reading time effectively.

At each meeting, staff members should be prepared to discuss matters covered in the above papers if and as requested by the Council.

Within two weeks after each Council meeting, each councilor, officer and AMA delegates should receive draft minutes of the previous meeting, approved by the Chairman of the Council.

At each Council meeting, final approval should be given to minutes of the previous meeting.

All councilors should receive brief minutes of each meeting of each Council committee, approved by the Chairman, within two weeks following the meeting.

Your Committee recommends adoption of this portion of the report.

Further Resolved, that the words (5) "a fiscal report" be added to Paragraph 2, Page 2 of the recommendations of the Survey Study Committee regarding Procedures to Improve Council Meetings, incorporated in the above resolution.

RESOLUTION NO. 34

Introduced by: The Medical Society of Milwaukee County

Subject: King-Anderson Bill, H.R. 3920, 88th Congress

WHEREAS, the King-Anderson bill, H.R. 3920, 88th Congress, and similar legislation would establish a compulsory and unnecessary federal health care program for persons over age 65, regardless of need; and

WHEREAS, it is the sincere conviction of the physicians of the State of Wisconsin that this bill would result in a lower standard of health care for the American people; and

WHEREAS, through voluntary health insurance plans an increasing number of persons are being protected against the costs of sickness; and

WHEREAS, existing federal law, the Kerr-Mills Act, which authorizes the establishment of federal-state programs of health care for the needy aged, has been enacted by all but a handful of states; now therefore be it

Resolved, That the State Medical Society of Wisconsin go on record as being unequivocally opposed to the King-Anderson Bill and any similar legislation.

RESOLUTION NO. 35

Introduced by: The Medical Society of Milwaukee County

Subject: Doctor William J. Egan

WHEREAS, Doctor William J. Egan has personified the finest qualities of the personal physician in his forty-five years of medical practice; and

WHEREAS, Doctor Egan has served with dedication not only his patients, but his profession; and

WHEREAS, Doctor Egan has served on committees and as a director of The Medical Society of Milwaukee County; and

WHEREAS, Doctor Egan has exhibited outstanding leadership as a Councilor of the State Medical Society of Wisconsin representing the physicians of the Twelfth District; and

WHEREAS, Doctor Egan has also contributed valuable guidance to civic organizations and local, state and national medical groups; and

WHEREAS, Doctor Egan has attained an exemplary record of accomplishment both as president-elect and president of the State Medical Society of Wisconsin during the years 1962 to 1964; and

WHEREAS, His service has always been characterized by prudent judgment, wise counsel, vigorous application of time and effort, and devotion to duty; now therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin officially acclaim and honor Doctor William J. Egan for his inestimable service to medicine and his community.

RESOLUTION NO. 36

Introduced by: The Medical Society of Milwaukee County

Subject: Civil Rights

WHEREAS, The State Medical Society of Wisconsin believes that any qualified physician should be eligible for membership in the American Medical Association, or any constituent association or component society thereof, regardless of race, religion or place of national origin; and

WHEREAS, Any such discrimination violates the spirit of the provisions of ARTICLE 11 of the Constitution of the American Medical Association; therefore be it

Resolved, That the House of Delegates of the American Medical Association at its meeting held in San Francisco, California, in June, 1964, be urged to adopt the following:

"That the Board of Trustees of the American Medical Association be, and hereby is, instructed to take such action as it deems necessary or appropriate to deny the rights and privileges of membership in the American Medical Association to members of any constituent association or component society thereof which denies membership to any qualified physician because of race, religion or place of national origin."

RESOLUTION NO. 37

Introduced by: The Medical Society of Milwaukee County

Subject: State Medical Society Group Disability Plan

WHEREAS, The policy contract for the Group Disability Plan available to members of the State Medical Society of Wisconsin specifically requires that a physician not on claim under the plan must be "actively engaged in the performance of the duties of his profession on a full time basis," and

WHEREAS, This provision excludes all physicians who are not "full dues paying" members, including those in the Affiliate classification who suffer a physical or other disability preventing the practice of medicine and those in the Associate membership category who are retired completely from the practice of medicine; and

WHEREAS, Such members are excluded from the benefits of this coverage when it is most needed, thereby creating hardship; therefore be it

Resolved, That the State Medical Society of Wisconsin act to change its contract to provide group disability coverage so as to include benefits for all members, whether or not they be in a full dues paying membership classification and actively engaged in medical practice.

RESOLUTION NO. 38

Introduced by: The Medical Society of Milwaukee County

Subject: Cigarette Smoking

WHEREAS, cigarette smoking has been shown to be a health hazard as a contributing factor to chronic bronchitis, emphysema, coronary artery disease and peptic ulcer; and

WHEREAS, smoking is injurious to the health of individuals of all ages; now therefore be it

Resolved, That the State Medical Society of Wisconsin cooperate with civic organizations, school authorities, and health agencies in the dissemination of appropriate information regarding the harmful effects of smoking; and be it further

Resolved, That this information be particularly directed to young people, it being recognized that children in graded schools as well as high school students should be apprised of the harmful effects of smoking to the end that they be prevented from acquiring the habit or encouraged to discontinue smoking.

RESOLUTION NO. 39

Introduced by the Wood County Medical Society

Resolved, That the Wood County Medical Society is in favor of establishing standards and procedures for direct admission to membership in the American Medical Association for those physicians who have been denied membership in constituent county societies by reason of race; further be it

Resolved, That this resolution be presented to the House of Delegates of the State Medical Society of Wisconsin at its annual meeting in May 1964 in order that the Wisconsin members of the House of Delegates of the American Medical Association may be instructed to seek implementation of this resolution at the national level.

(Resolutions Nos. 40–41–42 appear with Council Report)

■ REPORT OF TREASURER—YEAR ENDED DECEMBER 31, 1963

F. L. Weston, M.D., Madison, Treasurer

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years I am reporting to you here only on those funds which are the direct responsibility of the Treasurer, designated as the Society's "General Fund". Information on financial condition and income and expenditures of related activities of the Society is submitted to you separately, in accordance with a recommendation made to you in October, 1963 by the Reference Committee on Reports of Officers, which you adopted.

The following Exhibits and Schedules make up this report:

Exhibit A—Balance Sheet at December 31, 1963
Schedule A-1—Reconciliation of Net Worth at December 31, 1963
Exhibit B—Statement of Income and Expense—General Fund—Year Ended December 31, 1963
Exhibit C—Statement of Income and Expense—Special Assessment—Year Ended December 31, 1963

The records of the State Medical Society of Wisconsin have been audited for the year 1963 by Donald E. Gill & Company, Certified Public Accountants. A representative of this firm is present and available for consultation during the course of this Annual Meeting.

Exhibit A

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

BALANCE SHEET
December 31, 1963

ASSETS		
Cash	$166,314.86	
Accounts Receivable	1,584.25	
Due from Society Divisions—Current	30,217.17	
Due from Related Organizations—Current	7,708.29	
Guaranty Deposit	425.00	
Working Capital Advance—Wisconsin Medical Journal	13,671.52	
Furniture and Equipment—Cost Less Depreciation	9,196.10	
Prepaid Expenses and Deferred Charges	12,114.20	
TOTAL ASSETS		$241,231.39
LIABILITIES, RESERVES AND NET WORTH		
Liabilities		
Accounts Payable	$ 9,061.06	
Due Officers and Employees	687.56	
Dues—Suspense	293.50	
Accrued Payroll Taxes	26,619.00	
Prepaid Membership Dues	74,220.50	
Other Prepaid Income	15,645.00	
Accrued Expense	3,914.68	
Total Liabilities		$130,411.30
Reserves		
Special Assessment		23,205.70
Net Worth		
Surplus—General Fund	$ 63,659.37	
Net Worth of Wisconsin Medical Journal	13,671.52	
Surplus Reserved for Section on Medical History	1,123.50	
Surplus Reserved for Open Panel	4,130.00	
Surplus Reserved for Today's Health Subscriptions	5,000.00	
Total Net Worth		87,584.39
TOTAL LIABILITIES, RESERVES AND NET WORTH		$241,231.39

Schedule A-1

State Medical Society of Wisconsin
General Fund

Madison, Wisconsin

RECONCILIATION OF NET WORTH

Year Ended December 31, 1963

	Section on Medical History	Wisconsin Medical Journal	CARRY-OVER			Unappropriated Society Surplus	Total
			Open Panel	Legislative Expenditures	Todays Health		
Balance—January 1, 1963	$ 579.00	$16,062.81	$ 3,000.00	$ 1,825.00	$	$66,755.81	$88,222.62
Changes—1963	544.50	(2,391.29)	1,130.00	(1,825.00)	5,000.00	(3,096.44)	(638.23)
Balance—December 31, 1963	$ 1,123.50	$13,671.52	$ 4,130.00	$ —0—	$ 5,000.00	$63,659.37	$87,584.39

( ) Denotes Red Figure.

Exhibit B

State Medical Society of Wisconsin
General Fund

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1963

INCOME		
Membership Dues	$310,608.70	
Dues—Section on Medical History	550.00	
Annual Meeting	29,592.75	
Administrative Services	1,800.00	
Investment	1,835.00	
Miscellaneous Income	2,200.25	
Gain on Disposal of Fixed Assets	295.77	
TOTAL INCOME		$346,882.47
EXPENSES		
Auditing and Accounting Consultation Services	$ 6,370.15	
Conference Expense	31,642.44	
Depreciation	2,932.29	
Grants and Appropriations	8,830.00	
Legal Services	13,108.00	
Legislative Retainer	8,900.00	
Office Supplies	3,182.63	
Outside Services	12,118.66	
Payroll	140,805.01	
Payroll Taxes and Employee Benefits	12,255.56	
Postage and Express	12,906.70	
Printing and Forms	15,759.55	
Promotion	10,154.37	
Rent—Central Office	33,210.00	
Rent—Other	6,593.06	
Telephone and Telegraph	3,800.69	
Travel Expense—Staff	14,997.65	
Other Expenses	17,892.96	
Total	$355,459.72	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others	10,330.31	
TOTAL EXPENSES		$345,129.41
EXCESS—INCOME OVER EXPENSES (TO NET WORTH)		$ 1,753.06

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

Exhibit C

State Medical Society of Wisconsin
Special Assessment

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1963

Reserve for Special Assessment—January 1, 1963	$ 42,170.10
Special Assessment Income received in 1963	724.20
	$ 42,894.30
Less: Expense	19,688.60
Reserve for Special Assessment (To Reserves)	$ 23,205.70

Additional charges in excess of the maximum amount agreed upon for services and reimbursable expenses submitted by Booz, Allen & Hamilton, Inc. totaling $5,278.00 are not included above. Also any charges by the Medical Society of Milwaukee County or the State Medical Society for their added expense are not reflected here, nor any expenses reported or incurred after December 31, 1963.

■ CERTIFIED CONSOLIDATED BALANCE SHEET December 31, 1963

State Medical Society of Wisconsin and Related Organizations, Madison, Wisconsin

March 9, 1964

State Medical Society of Wisconsin
330 East Lakeside Street
Madison, Wisconsin

Gentlemen:

We have audited the accounts of the State Medical Society of Wisconsin, a corporation, Madison, Wisconsin for the year ended December 31, 1963. Our examinations have included the General Fund of the Society and all other of the divisions within the Society's corporate structure, which are:

Wisconsin Medical Journal
Wisconsin Physicians Service
Military Dependents' Medical Care Plan of the U. S. Government in Wisconsin

Our audit reports on each of these divisions of the Society for the year ended December 31, 1963 are separately submitted.

Also, we have audited the accounts of all those separate organizations related by direct control to

the State Medical Society of Wisconsin for the year ended December 31, 1963. These related organizations are:

SMS Realty Corporation
Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
Student Loan Fund of the State Medical Society of Wisconsin
Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

Our audit reports on all of these related organizations are separately submitted.

So that the financial condition of these various divisions and organizations at December 31, 1963 may be seen in consolidated form, we submit with this letter a Certified Consolidated Balance Sheet of the State Medical Society of Wisconsin and Related Organizations at December 31, 1963.

In addition we include with this letter the individual Certified Balance Sheets at December 31, 1963 and Statements of Income and Expense for the year ended that date for each division and related organization.

Respectfully submitted,
/s/ DONALD E. GILL & COMPANY
Certified Public Accountants
Madison, Wisconsin

State Medical Society of Wisconsin and Related Organizations
Madison, Wisconsin

CERTIFIED CONSOLIDATED BALANCE SHEET
December 31, 1963

ASSETS		
Cash	$ 505,189.55	
Current Receivables	787,547.89	
Invested Funds and Accrued Interest Receivable (Note 1)	5,004,387.14	
Long-Term Receivables	46,719.95	
Student Loans Receivable and Accrued Interest	94,251.95	
Land, Buildings, Equipment and Vehicles—Net Book Value (Note 2)	1,011,634.69	
Organization Expense	804.35	
Prepaid Expenses and Deferred Charges	54,524.93	
TOTAL ASSETS		$7,505,060.45
LIABILITIES, RESERVES AND CAPITAL		
Current Payables, Other Than Benefits	$ 108,570.42	
Mortgages and Debentures Payable	57,500.00	
Advances Held	5,000.00	
Deposits Held	2,021.29	
Old Outstanding Checks	5,445.66	
Benefits Payable	1,900,000.00	
Unearned Income	1,740,106.60	
Reserves of Medical Care Plans	2,877,262.29	
Special Assessment Reserve	23,205.70	
Total Liabilities and Reserves	$6,719,111.96	
Net Worth of General Fund	87,584.39	
Capital of SMS Realty Corporation	239,570.87	
Restricted Principal of Funds	458,793.23	
TOTAL LIABILITIES, RESERVES AND CAPITAL		$7,505,060.45
CONTINGENT LIABILITIES		
Contractual Future Adjustment of Income Under Federal Employee Program		See Note 3
Federal Income Taxes		See Note 4

Notes one to six inclusive which follow are an integral part of this Balance Sheet.

NOTES

1. Invested funds shown above are included in some cases at book value and in others at market value. In the case of the Pension Plan values on the books are adjusted annually to market values in accordance with provisions of the Trust Agreement. In the case of Wisconsin Physicians Service, U. S. Government Securities are valued at those market values prescribed by the National Association of Insurance Commissioners, which were, in total, less than book value by $45,020.15. For all securities of Wisconsin Physicians Service, the market value determined by reference to closing or bid prices in financial publications at December 31, 1963 was less than book value by $54,064.97. The securities owned by the Charitable, Educational and Scientific Foundation are shown at book value, which exceeded market value on December 31, 1963 by $397.25.

2. Fixed assets shown above at book value include those of the Charitable, Educational and Scientific Foundation, some of which are shown at appraisal values.

3. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the contract period which closed October 31, 1963 has not yet become final. Results of the succeeding period, which includes November and December 1963, will not be known for some time. Adverse results in total operations of the program could occasion an additional liability when this information is known.

4. During 1963 the Internal Revenue Service made an examination of the information returns which had been filed by the State Medical Society of Wisconsin. The Society was granted status as an exempt organization in a letter dated April 8, 1939. The Internal Revenue Service, through its examining agent, has concluded that the insurance operations of the Society are such as to warrant the imposition of a tax on this net income. The matter is presently in the conference level, pending a final determination by the District Director of Internal Revenue. No specific amount of tax has been proposed by the Internal Revenue Service at this time.

5. Certain payables and receivables between the State Medical Society of Wisconsin and its related organizations are eliminated from assets and liabilities above. These are:

Current Accounts	$ 12,804.68
Mortgage Loans	598,500.00
Leasehold Improvements (Shown as Reduction of Fixed Assets of SMS Realty Corporation)	27,500.00
Total	$638,804.68

6. The term, "Restricted Principal of Funds", in this Balance Sheet refers to the Net Worth of those organizations whose funds may be used solely for specifically designated purposes. There is no equity of the State Medical Society of Wisconsin in any of these funds. They are:

Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin

Student Loan Fund of the State Medical Society of Wisconsin

Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1963

	State Medical Society of Wisconsin	SMS Realty Corporation	Restricted Funds	Total
Balance January 1, 1963	$88,222.62	$210,234.30	$391,726.02	$690,182.91
Excess—Income Over Expense—1963	1,753.06	--	--	1,753.06
Increases in Fund Capital		29,336.57	67,067.21	96,403.78
Total	$89,975.68	$239,570.87	$458,793.23	$788,339.78
Decrease in Fund Capital	2,391.29	--	--	2,391.29
Balance—December 31, 1963	$87,584.39	$239,570.87	$458,793.23	$785,948.49

CERTIFICATE

We have audited the accounts of the State Medical Society of Wisconsin, a Wisconsin corporation, Madison, Wisconsin and accounts of its related organizations for the year ended December 31, 1963. Our audit included all divisions of the Society within its corporate structure which are: General Fund, Wisconsin Medical Journal, Wisconsin Physicians Service, and Military Dependents' Medical Care Plan of the U. S. Government in Wisconsin. It included also all those organizations related by direct control to the State Medical Society of Wisconsin which are: SMS Realty Corporation, a corporation; Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin, a corporation; Student Loan Fund of the State Medical Society of Wisconsin, a trust; and Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin, a trust. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Consolidated Balance Sheet, including the six notes which are a part of it, presents fairly the financial condition of the State Medical Society of Wisconsin and its related organizations at December 31, 1963, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

Madison, Wisconsin
March 9, 1964

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Current Assets		
Cash		$166,314.86
Accounts Receivable—General		1,236.25
Accounts Receivable—Employees		348.00
Due From Society Divisions		30,217.17
Due From Related Organizations		7,708.29
Guaranty Deposit		425.00
Unexpired Insurance		744.82
Total Current Assets		$206,994.39
Long-term and Fixed Assets		
Working Capital Advance—Wisconsin Medical Journal	$ 13,671.52	
Furniture and Equipment—Cost Less Depreciation	9,196.10	
Total Long-term and Fixed Assets		22,867.62
Prepaid Expenses and Deferred Charges		
Supplies and Forms Inventory	$ 6,514.40	
Deferred Expenses	4,854.98	
Total Prepaid Expenses and Deferred Charges		11,369.38
TOTAL ASSETS		$241,231.39
LIABILITIES, RESERVES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 10,663.30	
Dues—Suspense	293.50	
Accrued Expense	3,000.00	
Accrued Payroll Taxes	26,619.00	
Total Current Liabilities		$ 40,575.80
Deferred Income		
Prepaid Dues and Other Income		89,865.50
TOTAL LIABILITIES		$130,441.30
Reserves		
Special Assessment Unexpended Funds		23,205.70
NET WORTH		
Net Worth of General Fund - Jan. 1, 1963	$ 88,222.62	
Excess—Income over Expenses—Year 1963	1,753.06	
Total	$ 89,975.68	
Less: Decrease in Working Capital Advance to Wisconsin Medical Journal	2,391.29	
TOTAL NET WORTH December 31, 1963		87,584.39
TOTAL LIABILITIES, RESERVES AND CAPITAL		$241,231.39

Note: Reserves of Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, are not included in this statement.

STATEMENT OF INCOME AND EXPENSE—GENERAL FUND
Year Ended December 31, 1963

INCOME		
Membership Dues		$310,608.70
Dues—Section on Medical History		550.00
Annual Meeting		29,592.75
Administrative Services		3,303.26
Income from Investments		1,835.00
Miscellaneous Income		696.99
Gain on Disposal of Fixed Assets		295.77
TOTAL INCOME		$346,882.47
EXPENSES		
Auditing and Accounting Consultation Services	$ 6,370.15	
Conference Expense	31,642.44	
Grants and Appropriations	8,830.00	
Legal Services—General	13,108.00	
Legislative Retainer	8,900.00	
Postage and Express	12,906.70	
Printing and Forms	15,759.55	
Promotion	10,154.37	
Rent—Central Office	33,210.00	
Travel Expense—Staff	14,997.65	
Payroll	140,805.01	
Payroll Taxes and Employee Benefits	12,255.56	
Other Expenses	46,520.29	
Total	$355,159.72	
Less: Expenses Charged Out for Services to Others (See Note)	10,330.31	
TOTAL EXPENSES		345,129.41
EXCESS OF INCOME OVER EXPENSES		$ 1,753.06

Note: This total includes $1,529.85 of 1962 expenses of the Management Survey charged to the Special Assessment Fund in 1963.

STATEMENT OF INCOME AND EXPENSE—SPECIAL ASSESSMENT FUND
Year Ended December 31, 1963

INCOME		
Special Assessments Received		$ 724.20
EXPENSES		
Accounting Consultation Services	$ 1,024.00	
Conference Expense	2,330.70	
Legal Services	6,073.00	
Printing	6,161.44	
All Other Expenses	4,099.46	
TOTAL EXPENSES		19,688.60
Excess of Income over Expense Deficit		($ 18,964.40)

( ) Denotes Red Figure.

CERTIFICATE

We have audited the accounts of the General Fund of the State Medical Society of Wisconsin, a corporation of Madison, Wisconsin for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet and Statements of Income and Expense present fairly the financial condition of the General Fund of the State Medical Society of Wisconsin at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

Madison, Wisconsin
February 24, 1964

Exhibit A

WISCONSIN MEDICAL JOURNAL

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Current Assets		
Cash in Bank	$ 9,699.99	
Accounts Receivable—Advertisers	8,002.70	
Accounts Receivable—Other	301.87	
Due from Wisconsin Physicians Service	72.00	
Copyright Deposits	24.00	
Postage Deposits	246.38	
Unexpired Insurance	7.92	
Total Current Assets		$18,354.86
Fixed Assets		
Furniture and Equipment	$ 1,484.74	
Less: Accumulated Depreciation	619.69	
Total Fixed Assets		865.05
Deferred Charges		
Mailing Envelope Inventory	$ 34.94	
Prepaid Cuts	11.43	
Deferred Blue Book Expenses	860.00	
Total Deferred Charges		906.37
TOTAL ASSETS		$20,126.28
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 3,845.52	
Due State Medical Society of Wisconsin	2,609.24	
Total Liabilities		$ 6,154.76
Capital—January 1, 1963	$16,062.81	
Less: Excess of Expense Over Income—1963	2,391.29	
Capital—December 31, 1963		13,671.52
TOTAL LIABILITIES AND CAPITAL		$20,126.28

Note: The capital of the Wisconsin Medical Journal is carried as a working capital advance among the assets of the State Medical Society of Wisconsin General Fund.

Exhibit B

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1963

INCOME		
Advertising Income	$40,157.52	
Subscriptions and Supplemental Income	811.55	
State Medical Society Appropriation	3,000.00	
Reprint Income	1,482.36	
Miscellaneous Income	22.00	
TOTAL INCOME		$45,473.43
EXPENSE		
Direct Payroll	$ 6,205.43	
Printing	33,741.59	
Cuts	720.60	
Postage	1,568.47	
Rent	810.00	
Reprints	1,256.10	
Advertising Discount	17.73	
Copyright Expense	48.00	
Telephone	46.46	
Office Supplies and Expense	254.29	
Accounting Services	438.75	
Advertising Commissions	192.48	
Depreciation	153.04	
Insurance—Employees	312.41	
Insurance—General	49.98	
Legal Services	936.50	
Miscellaneous Expense	370.11	
Outside Service	60.00	
Workmen's Compensation	4.97	
Printing and Forms	361.80	
Social Security Tax	253.58	
Federal Unemployment Tax	33.78	
Wisconsin Unemployment Tax	28.65	
TOTAL EXPENSE		47,864.72
EXCESS OF INCOME OVER EXPENSE		($ 2,391.29)

( ) Denotes Red Figure.

CERTIFICATE

We have audited the accounts of the Wisconsin Medical Journal, A Division of the State Medical Society of Wisconsin, Madison, Wisconsin for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet and Statement of Income and Expense present fairly the financial condition of the Wisconsin Medical Journal at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

Madison, Wisconsin
February 24, 1964

Exhibit A

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Current Assets		
Cash	$ 214,394.55	
Due from Agents	992.76	

Due from Plan Administrator, Federal Employee Program	12,146.12	
Due from Medicare—Current	7,409.81	
Premiums Receivable	695,848.18	
Refunds Receivable	8,748.77	
Other Current Receivables	2,042.70	
Unexpired Insurance	2,336.66	
Current Investments and Accrued Interest (Note 1)	4,673,094.41	
Total Current Assets		$5,617,013.96
Long-term and Fixed Assets		
Advance to Medicare	$ 100,000.00	
Due from Associated Hospital Service, Inc.	30,669.95	
Mortgage Loans Receivable	610,500.00	
Real Estate, Held as Investment—Cost Less Depreciation	21,078.01	
Improvements, Equipment and Automobiles—Cost Less Depreciation	87,939.96	
Total Long-term and Fixed Assets		850,187.92
Deferred Charges		
Supplies and Forms Inventories	$ 32,240.98	
Other Deferred Expense	2,674.54	
Total Deferred Charges		34,915.52
TOTAL ASSETS		$6,502,117.40
LIABILITIES AND RESERVES		
Current Liabilities		
Accounts Payable	$ 14,556.24	
Due Related Interests—Current	32,776.32	
Due Plan Administrator—Federal Employee Program	5,217.73	
Accrued Expenses	7,318.70	
Old Outstanding Checks	5,445.66	
Premium Deposits	2,021.29	
Subscriber Benefits Payable	1,900,000.00	
Merit Rating Credits Payable	8,388.07	
Total Current Liabilities		$1,975,724.01
Deferred Income		
Premiums Not Earned	$1,648,131.10	
Unearned Administrative Income	1,000.00	
Total Deferred Income		$1,649,131.10
TOTAL LIABILITIES		$3,624,855.11
Reserves		
Reserves—January 1, 1963	$2,479,816.66	
Excess—Income over Expenses—Year 1963	442,465.78	
Total	$2,922,282.44	
Less: Transfer to Reserve for Market Values of Securities	45,020.15	
Total Reserves		2,877,262.29
TOTAL LIABILITIES AND RESERVES		$6,502,117.40
CONTINGENT LIABILITIES		
Contractual Future Adjustment of Income Under Federal Employee Program		See Note 2
Federal Income Tax		See Note 3

NOTES

(1) U. S. Government Securities included above are at market value on December 31, 1963 in accordance with valuation data prescribed by the National Association of Insurance Commissioners. Other securities are shown above at book value, which was less than this market value on December 31, 1963. Had all securities been valued at market values shown in financial publications at December 31, 1963, the values would compare as follows:

	U. S. Government Securities	Commercial Bonds
Book Values	$3,921,160.15	$739,803.09
NAIC Market Values	$3,876,140.00	$740,992.10
Commercial Market Values	$3,871,476.39	$735,421.88

(2) Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the contract period which closed October 31, 1963 has not yet become final. Results of the succeeding period, which includes November and December 1963, will not be known for some time. Adverse results in total operations of the program could occasion an additional liability when this information is known.

(3) During 1963 the Internal Revenue Service made an examination of the information returns which had been filed by the State Medical Society of Wisconsin. The Society was granted status as an exempt organization in a letter dated April 8, 1939. The Internal Revenue Service, through its examining agent, has concluded that the insurance operations of the Society are such as to warrant the imposition of a tax on this net income. The matter is presently in the conference level, pending a final determination by the District Director of Internal Revenue. No specific amount of tax has been proposed by the Internal Revenue Service at this time.

STATEMENT OF INCOME AND EXPENSE
January 1, 1963 to December 31, 1963

Net Earned Premium Income		$13,244,611.07
Benefits Incurred		11,469,515.84
Net Underwriting Gain		$ 1,775,095.23
Administrative Expenses		1,517,089.61
Net Operating Gain		$ 258,005.62
Investment Income	$180,682.18	
Other Income	3,777.98	
Total		184,460.16
Excess—Income over Expenses		$ 442,465.78

CERTIFICATE

We have audited the accounts of Wisconsin Physicians Service, A Division of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet and accompanying Statement of Income and Expense present fairly the financial condition of Wisconsin Physicians Service at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ Donald E. Gill & Company
Certified Public Accountants

Madison, Wisconsin
February 24, 1964

Exhibit B

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1963

INCOME	
Earned Premium Income	$13,257,683.91
Less: Merit Rating Credits	13,072.84
Net Earned Premium Income	$13,244,611.07
Benefits Incurred	11,469,515.84
Net Underwriting Gain	$ 1,775,095.23

EXPENSES			
Agents Expense		$ 52,957.92	
Joint Plan Expense—Federal Employee Program		615.76	
Actuarial Services		3,571.65	
Auditing and Accounting Consultation Services		4,296.25	
Association Dues		9,733.75	
Automobile Expense		2,136.57	
Cafeteria Expense		3,783.06	
Conference Expense		15,155.18	
Consultation Services		13,415.00	
Amortization of Leasehold Improvements		2,000.00	
Depreciation		15,742.99	
Field Service Expense		6,667.00	
Grants and Appropriations		1,155.00	
Insurance—General		5,975.95	
Insurance—Employees		29,703.08	
Legal Services		23,079.30	
Medical Consultant Services		4,500.00	
Miscellaneous Expense		14,762.80	
Office Supplies and Expense		9,671.93	
Outside Underwriting Services		4,959.28	
Payroll		801,003.60	
Sales Incentive Bonus		6,732.30	
Severance Payment		412.81	
Postage		41,884.67	
Printing and Forms		40,783.59	
Promotion		110,851.25	
Rent—Offices		155,089.10	
Rental—Data Processing Equipment		37,527.37	
Repairs and Maintenance—Equipment		2,793.16	
Resource Material		683.93	
Retirement Plan Contributions		20,687.19	
Personal Property Tax		1,839.14	
Payroll Taxes		29,131.73	
Telephone and Teletype		12,922.38	
Travel and Auto Rental Expense—Staff		58,587.43	
Total		$1,544,812.12	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others		27,722.51	
Net Administrative Expense			1,517,089.61
Net Gain from Operations			$ 258,005.62
Investment and Other Income			
Interest Earned		$ 179,272.81	
Amortization of Premiums and Discounts		5,917.71	
Rental Income		910.00	
Total		$ 186,100.52	
Less: Investment Consultation Expense	$2,500.37		
Securities Safekeeping Expense	1,335.13		
Rental Property Expense and Taxes	1,227.24		
Loss on Disposal of Securities	355.60	5,418.34	
Net Investment Income		$ 180,682.18	
Other Income		3,777.98	
Total Investment and Other Income			184,460.16
Excess—Income over Expenses			$ 442,465.78

Exhibit A

MILITARY DEPENDENTS' MEDICAL CARE PLAN OF THE U. S. GOVERNMENT IN WISCONSIN

A Division of the State Medical Society of Wisconsin
Madison, Wisconsn

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Current Assets		
Cash in First National Bank, Madison, Wisconsin	$ 49,718.86	
Cash in and in Transit to Dakota National Bank, Bismarck, N. D.	24,869.45	
Due From U. S. Government, Office for Dependents' Medical Care	31,167.29	
Due From State Societies—Sub Contracts	2,005.90	
Suspended Claims	201.00	
TOTAL ASSETS		$107,962.50
LIABILITIES		
Current Liabilities		
Due Wisconsin Physicians Service—Current	$ 7,409.81	
Due North Dakota State Medical Association	552.69	
Total Current Liabilities	$ 7,962.50	
Advances		
Advanced Funds—Wisconsin Physicians Service	100,000.00	
TOTAL LIABILITIES		$107,962.50

Exhibit B

STATEMENT OF INCOME AND EXPENSES
Year Ended December 31, 1963

INCOME		
U. S. Government, Office for Dependents' Medical Care		$ 22,492.33
Indiana State Medical Association		2,671.13
Iowa State Medical Society		1,505.43
Minnesota State Medical Association		2,162.86
South Dakota State Medical Association		405.12
TOTAL INCOME		$ 29,236.87
EXPENSES		
Accounting Services	$ 652.25	
Legal Services	9.00	
Office Supplies and Expense	154.24	
Payroll	13,676.16	
Postage and Express	1,312.75	
Printing and Forms	1,203.08	
Rent	180.00	
Telephone Service	183.42	
Overhead Expense	6,827.00	
Travel Expense	44.64	
Machine Service Expense	4,973.75	
Miscellaneous Expense	20.58	
TOTAL EXPENSES		29,236.87
BALANCE		$ None

CERTIFICATE

We have audited the accounts of Military Dependents' Medical Care Plan of the U. S. Government in Wisconsin, A Division of the State Medical Society of Wisconsin, Madison, Wisconsin for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet and Statement of Income and Expense present fairly the financial condition of the Plan at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

Madison, Wisconsin
February 28, 1964

Exhibit A

SMS REALTY CORPORATION

Madison, Wisconsin

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Current Assets		
Cash	$ 11,837.29	
Accounts Receivable	185.76	
Due From Wisconsin Physicians Service	5,096.39	
Investments	80,622.51	
Cafeteria, Fuel and Supplies Inventories	2,499.95	
Accrued Interest Receivable	476.57	
Unexpired Insurance	806.25	
Total Current Assets		$101,521.72

Fixed Assets		
Land, Buildings, Improvements, Equipment and Automobiles	$955,024.96	
Less: Accumulated Depreciation	175,847.13	
Net Book Value	$779,177.83	
Less: Leasehold Improvements Paid by Wisconsin Physicians Service	27,500.00	
Total Fixed Assets		751,677.83
Intangible Assets		
Organization Expense		644.35
Deferred Charges		
Prepaid Licenses		50.00
TOTAL ASSETS		$853,896.90

LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable—Trade	$ 3,251.88	
Due State Medical Society of Wisconsin	4,876.24	
Accrued Sales Tax	197.91	
Total Current Liabilities		$ 8,326.03
Long-Term Liabilities		
Debenture Payable	$ 7,500.00	
Mortgage Notes Payable	598,500.00	
Total Long-Term Liabilities		606,000.00
TOTAL LIABILITIES		$614,326.03

BALANCE SHEET

December 31, 1963

NET WORTH		
Investment of State Medical Society	$150,245.96	
Donated Capital	3,300.00	
Reserves	70,439.91	
Unappropriated Surplus	15,585.00	
TOTAL NET WORTH		239,570.87
TOTAL LIABILITIES AND CAPITAL		$853,896.90

RECONCILIATION OF NET WORTH

January 1, 1963 to December 31, 1963

	Balance 1/1/63	Increase From Operations	Balance 12/31/63
Investment of State Medical Society	$150,245.96	$	$150,245.96
Donated Capital	$ 3,300.00	$	$ 3,300.00
Reserves			
For Repair and Maintenance	$ 20,738.20	$ 1,857.18	$ 22,595.38
For Return on Investment	34,520.00	5,000.00	39,520.00
For Funding Appreciation	4,495.70	3,828.83	8,324.53
Total	$ 59,753.90	$ 10,686.01	$ 70,439.91
Unappropriated Surplus (Deficit)	($ 3,065.56)	$ 18,650.56	$ 15,585.00
TOTAL NET WORTH	$210,234.30	$ 29,336.57	$239,570.87

( ) Denotes Red Figure.

Exhibit B

STATEMENT OF INCOME AND EXPENSE

January 1, 1963 to December 31, 1963

INCOME		
Rental Income	$188,067.50	
Cafeteria Income	30,607.96	
Dividend Income	900.00	
Interest Income	557.95	
Other Income	1,613.63	
Gain on Disposal of Fixed Assets	702.67	
TOTAL INCOME		$222,449.71
EXPENSE		
Building Operation	$102,696.44	
Services	50,015.15	
Administration	40,401.55	
TOTAL EXPENSES		193,113.14
EXCESS - INCOME OVER EXPENSE		$ 29,336.57
Transfer to Reserve for Repair and Maintenance	$ 1,857.18	
Transfer to Reserve for Return on Investment	5,000.00	
Transfer to Reserve for Funding Appreciation	3,828.83	
Transfer to Unappropriated Surplus	18,650.56	
TOTAL		$ 29,336.57

Note: The items shown above representing payroll and related costs are paid by the State Medical Society of Wisconsin as the employer. SMS Realty Corporation has no employees and is not an employer, but reimburses the Society for amounts of payroll, payroll taxes and related costs.

CERTIFICATE

We have audited the accounts of SMS Realty Corporation, Madison, Wisconsin for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet, Reconciliation of Net Worth and Statement of Income and Expense present fairly the financial condition of the Corporation at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ Donald E. Gill & Company
Certified Public Accountants

Madison, Wisconsin
February 21, 1964

Schedule B-1

ANALYSIS OF OPERATING EXPENSES

January 1, 1963 to December 31, 1963

	Building Operation	Services	Administration	Total
Legal and Accounting Services	$	$	$ 1,506.50	$ 1,506.50
Managerial Service	1,890.00			1,890.00
Janitorial and Part-Time Help	17,441.09			17,441.09
Internal Accounting			840.00	840.00
Messenger		2,864.67		2,864.67
Switchboard Operator		4,408.47		4,408.47
Payroll Taxes			1,205.47	1,205.47
Group Insurance			890.55	890.55
Retirement Plan Contribution			424.96	424.96
Telephone and Telegraph		10,951.52		10,951.52
Gas and Light	8,423.37			8,423 37
Water and Sewer	1,361.77			1,361.77
Heat	3,403.13			3,403.13
Building Supplies	4,586.81			4,586.81
Repair and Maintenance	7,642.82			7,642.82
Gas, Oil and Maintenance of Autos		1,182.53		1,182.53
Insurance	1,813.15			1,813.15
Interest Expense (Schedule A-3)			29,329.35	29,329.35
Property Taxes	19,830.32			19,830.32
Depreciation—Net of Amortization of Improvements (Schedule A-2)	36,303.98			36,303.98
Cafeteria Expense		30,607.96		30,607.96
Rental Property Expense			1,272.95	1,272.95
Miscellaneous Investment Expense			20.00	20.00
Other Expense			4,911.77	4,911.77
TOTAL	$102,696.44	$50,015.15	$40,401.55	$193,113.14

Exhibit A

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION INCORPORATED OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS			
Current Assets			
Cash on Hand		$ 2,751.00	
Cash in Banks		19,777.12	
Accounts Receivable—General		63.06	
Pledges Receivable—Current		22,950.00	
Accrued Interest Receivable		823.78	
Unexpired Insurance		438.79	
Total			$ 46,803.75
Long-Term Assets			
Notes Receivable—Student Loans	$93,587.05		
Less: Interest of Student Loan Fund in Notes Receivable	1,705.00	91,882.05	
Notes Receivable—Nurse Loans		150.00	
Other Loans Receivable		1,800.00	
Pledges Receivable—Long-Term		14,100.00	
Common Stocks at Cost (Market Value $7,453.40)		7,850.65	
Savings and Loan Certificates		40,000.00	
Certificates of Deposit		9,000.00	
Total			164,782.70
Fixed Assets			
Land, Buildings, Museum Fixtures and Equipment for Loan—Net (Schedule A-1)			140,877.74
Intangible Assets			
Organization Expense			160.00
Deferred Charges			
Expenses Deferred			394.35
TOTAL ASSETS			$353,018.54

BALANCE SHEET
December 31, 1963

LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 14,526.41	
Due State Medical Society of Wisconsin	2,832.05	
Accrued Interest Payable	122.22	
Total		$ 17,480.68
Deferred Income		
Advance Receipts—1964 Programs	$ 1,030.00	
Unallocated Contributions	80.00	
Total		1,110.00
Funded Liabilities		
Mortgage Notes Payable		50,000.00
TOTAL LIABILITIES		$ 68,590.68
Capital		
Restricted Capital	$226,531.53	
Unrestricted Capital	57,896.33	
Total Capital		284,427.86
TOTAL LIABILITIES AND CAPITAL		$353,018.54

Note: Fixed Assets above are shown at values determined by appraisals of real estate and equipment and cost of additions purchased or constructed.

Exhibit B

RECONCILIATION OF CAPITAL ACCOUNTS
Year Ended December 31, 1963

	Restricted	Unrestricted	Total
Balance—Jan. 1, 1963	$186,951.64	$56,107.04	$243,058.68
Excess—Income over Expense Jan. 1, 1963 to June 30, 1963	6,975.71	(662.59)	6,313.12
Transfers	22.61	(22.61)	
Balance—June 30, 1963	$193,949.96	$55,421.84	$249,371.80
Excess—Income over Expense July 1, 1963 to December 31, 1963	32,062.09	2,993.97	35,056.06
Transfers	519.48	(519.48)	
Balance—December 31, 1963	$226,531.53	$57,896.33	$284,427.86

Exhibit C

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1963

	1/1/63–6/30/63	7/1/63–12/31/63	1963 Total
INCOME			
Contributions			
Restricted as to Use	$ 9,910.31	$55,525.90	$65,436.21
Not Restricted	2,904.85	5,725.38	8,630.23
Memorial Contributions	745.00	1,267.94	2,012.94
Contributions to Invested Capital	4,500.00		4,500.00
Total Contributions	$18,060.16	$62,519.22	$80,579.38
Fees for Scientific Teaching Activities	408.00	478.00	886.00
Interest Income	812.19	816.17	1,628.36
Dividend Income	800.20	834.30	1,634.50
Sale of Materials	15.00	13.00	28.00
TOTAL INCOME	$20,095.55	$64,660.69	$84,756.24
EXPENSES			
Auditing and Accounting Consultation Services	$ 527.28	$ 1,359.05	$ 1,886.33
Conference Expense	1,794.03	2,592.84	4,386.87
Promotion	376.03	1,284.47	1,660.50
Depreciation	1,776.36	1,852.45	3,628.81
Grants and Appropriations	400.00	5,526.90	5,926.90
Insurance	398.39	236.78	635.17
Legal Services	101.49		101.49
Miscellaneous Expense	170.41	65.13	235.54
Supplies and Expense	80.96	362.30	443.26
Outside Services	84.84	12,047.31	12,132.15
Payroll Charges	1,477.29	1,249.98	2,727.27
Postage and Express	787.66	917.56	1,705.22
Printing and Forms	1,020.69	459.78	1,480.47
Telephone and Telegraph	121.85	100.20	222.05
Travel Expense	469.87	90.60	560.47
Interest Expense	1,375.00	1,375.00	2,750.00
Machine Service	102.78	79.28	182.06
Commissions	397.50	5.00	402.50
Uncollectible Items	2,320.00		2,320.00
TOTAL EXPENSES	$13,782.43	$29,604.63	$43,387.06
EXCESS—INCOME OVER EXPENSE	$ 6,313.12	$35,056.06	$41,369.18

CERTIFICATE

We have audited the accounts of the Charitable, Educational, and Scientific Foundation Incorporated of the State Medical Society of Wisconsin, Madison, Wisconsin for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet, Reconciliation of Capital Accounts and Statement of Income and Expense present fairly the financial condition of the Foundation at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ Donald E. Gill & Company
Certified Public Accountants

Madison, Wisconsin
March 9, 1964

HOUSE OF DELEGATES
Interim Session—Oct. 10–11, 1964
SMS Headquarters—Madison

STUDENT LOAN FUND OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, Wisconsin

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Interest in Notes Receivable—Student Loans		$1,705.00
LIABILITIES AND CAPITAL		
Liabilities		$ None
Student Loan Fund Capital		1,705.00
TOTAL LIABILITIES AND CAPITAL		$1,705.00

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1963

INCOME	
None	$ None
EXPENSE	
None	None
Excess—Income over Expense	$ None

CERTIFICATE

We have audited the accounts of the Student Loan Fund of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet and Statement of Income and Expense present fairly the financial condition of the Fund at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

Madison, Wisconsin
March 9, 1964

Exhibit A

EMPLOYEES' PENSION PLAN AND TRUST AGREEMENT OF STATE MEDICAL SOCIETY OF WISCONSIN

MADISON, WISCONSIN

CERTIFIED STATEMENTS
BALANCE SHEET
December 31, 1963

ASSETS		
Current Assets		
Cash in Bank		$ 5,826.43
Accounts Receivable		446.65
Dividends Receivable		165.50
U. S. Government Securities—At Cost	$ 63,133.37	
Adjustment to Market	(640.92)	62,492.45
Corporate Bonds—At Cost	$ 37,785.18	
Adjustment to Market	227.32	38,012.50
Common Stocks—At Cost	$ 50,785.40	
Adjustment to Market	(1,137.90)	49,647.50
Investments in Savings and Loan Associations		30,000.00
Accrued Interest Receivable		1,031.67
Total Current Assets		$187,622.70
Deferred Charges		
Deferred Investment Expense		54.92
TOTAL ASSETS		$187,677.62
LIABILITIES AND PRINCIPAL		
Current Liabilities		
Accounts Payable		$ 15,017.25
TOTAL LIABILITIES		$ 15,017.25

Principal of Fund—January 1, 1963		$146,962.34	
Employer Contribution	$28,572.18		
Employee Contributions	11,428.88		
Total Contributions	$40,001.06		
Payment to Terminating Employee	$16,649.94		
Portion of Account Forfeited	3,129.65		
Total Deductions	19,779.59		
Net Increase Other Than Fund Earnings		20,221.47	
Fund Earnings (Exhibit B)		5,476.56	
Principal of Fund—December 31, 1963			172,660.37
TOTAL LIABILITIES AND PRINCIPAL			$187,677.62

Note: Securities are shown above at market value as required by the trust agreement. This treatment has been followed consistently since the inception of the trust.

( ) Denotes Red Figures.

Exhibit B

STATEMENT OF FUND EARNINGS
Year Ended December 31, 1963

INCOME		
Dividends on Common Stocks	$1,753.72	
Dividends on Savings and Loan Investments	1,200.00	
Total Dividends		$2,953.72
Interest Earned		3,177.74
TOTAL INCOME		$6,131.46
EXPENSE		
Investment Counsel Expense	$ 588.13	
Loss in Market Value of Securities	66.77	
TOTAL EXPENSE		654.90
Net Fund Earnings		$5,476.56

CERTIFICATE

We have audited the accounts of the Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin, a trust, of Madison, Wisconsin for the period January 1, 1963 to December 31, 1963. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances.

In our opinion the above Balance Sheet and accompanying Statement of Fund Earnings present fairly the financial condition of the Trust at December 31, 1963 and the result of operations for the year ended that date in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

Madison, Wisconsin
January 8, 1964

TRANSACTIONS OF HOUSE OF DELEGATES

ANNUAL MEETING • MAY 10–12, 1964 • MILWAUKEE

SUNDAY EVENING SESSION

May 10, 1964

The First Session of the House of Delegates, State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, Wisconsin, on May 10–12, 1964, convened at 7:10 p.m., R. E. Callan, M.D., Speaker of the House of Delegates, presiding.

Speaker Callan: It is a sincere pleasure to welcome you to Milwaukee for this 123rd Annual Meeting of the House of Delegates of the State Medical Society of Wisconsin.

Every meeting of this House has been important, but beyond a doubt this meeting sees us facing problems that are deserving of our utmost consideration. We must, together in this body assembled, accept our responsibilities as the legislative body of our State Medical Society, representing 3,884 members. We must face squarely the challenges and problems confronting us, and lay down the basic directives that will lead to their solution.

It is up to you to direct this Society to go in the direction you think it should. I know that you, individually and collectively, are dedicated to the task at hand, and that you will put forth your best efforts to assure the success of this annual meeting.

REPORT OF CREDENTIALS COMMITTEE

Speaker Callan: We will now have the report of the Credentials Committee. This Committee is composed of Drs. D. J. Carlson, Milwaukee, Chairman; and W. D. Hamlin, Mineral Point and J. W. Boren, Jr., Marinette. Will the Chairman please report.

Dr. D. J. Carlson (Milwaukee): The Committee on Credentials has verified the registration of 67 Delegates and 8 Alternate Delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed that Dr. J. W. Rupel, of Wood, will act as Delegate for the regular Delegate and Alternate who are unable to attend.

I move that the attendance roll of Delegates, Alternate Delegates and especially appointed Delegates, totaling 75, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

REFERENCE COMMITTEE APPOINTMENTS

Speaker Callan: Announcement of reference committee appointments is made at this time. After consultation with Vice Speaker Carey I have appointed the following committees:

To the Reference Committee on Reports of Officers:

James V. Bolger, Jr., M.D., Waukesha, Chairman
H. F. Twelmeyer, M.D., Wauwatosa
F. M. Hilpert, M.D., Racine
C. J. Strang, M.D., Barron
M. V. Overman, M.D., Neillsville

To the Reference Committee on Reports of Standing Committees:

F. E. Gehin, M.D., Stevens Point, Chairman
G. W. Hilliard, M.D., Milwaukee
W. T. Russell, M.D., Sun Prairie
W. F. Henken, M.D., Racine
C. A. Grand, M.D., Ashland

To the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws:

T. J. Nereim, M.D., Madison, Chairman
E. P. Rohde, M.D., Galesville
G. A. Behnke, M.D., Kaukauna
D. R. Griffith, M.D., Eau Claire
G. E. Collentine, Jr., M.D., Milwaukee

Non-voting members:

L. W. Schrank, M.D., Waupun
C. J. Picard, M.D., Superior

APPROVAL OF 1963 ANNUAL MEETING PROCEEDINGS AND INTERIM SESSION PROCEEDINGS

The Chair will now entertain a motion to approve the record of proceedings of the 1963 Annual Meeting as printed in the November 1963 issue of the WISCONSIN MEDICAL JOURNAL beginning at page 451.

Dr. G. A. Behnke (Kaukauna): I so move.

(Motion seconded and carried.)

Speaker Callan: I will now entertain a motion that the record of proceedings of the Interim Session, as printed in the December 1963 issue of the WISCONSIN MEDICAL JOURNAL, beginning at page 526, stand approved.

Dr. W. T. Russell (Sun Prairie): I so move.

(Motion seconded and carried.)

Speaker Callan: Standing rules of procedure are stated on page 3 of the House of Delegates Calendar. Is it the pleasure of the House that these rules be adopted as the standing rules of this session:

Dr. V. J. Burch (Racine): I so move.

(Motion seconded and carried.)

■ REPORT OF THE PRESIDENT—MAY, 1964

Dr. W. J. Egan (Milwaukee): It has been a delightful and a very trying year. It appears in order that I give a brief report of my presidential experience during this last year.

We have a great and glorious Society. We would be better off if we followed all the rules, regulations, Constitution and Bylaws that have been laid down by our outstanding forebears, and if we had done so we would have been in much less trouble.

The climate is better. We are better off than we were a few years ago. We are much more relaxed. On the other hand, as a member from Green County remarked, this may be just a lull between the storms.

I believe it is mandatory for you delegates to make certain that no dispute between or among any of us is ever reflected publicly. That should be followed. No good is accomplished if it is not followed.

I worked for three or four weeks preparing a talk to you this evening and then I threw it away, because I wanted to talk to you freely. We all come from the same schools and from the same circumstances. It is beholden to us to work together for the welfare of this Society. I will support entirely and fully everything President Curran does next year. I wish him a lot of luck.

■ REPORT OF THE PRESIDENT-ELECT—MAY, 1964

Dr. W. P. Curran's report appeared in the June 1964 issue of the WISCONSIN MEDICAL JOURNAL at page 275.

Dr. W. P. Curran (Antigo): Under the Bylaws the President-elect is privileged to submit appointments for standing committees of the Society where terms expire or vacancies occur. These committee appointments are as follows:

To the Committee on Cancer: There are three terms expiring. I should like to appoint Dr. John K. Scott of Madison and Dr. Guy W. Holmes of Marinette, and reappoint Dr. G. H. Williams of Marshfield. I should like to appoint Dr. G. A. Smiley of Delavan as Chairman, and Dr. R. C. Glise of Richland Center as Vice-chairman.

To the Committee on Grievances: Three terms expire on this Committee. May I appoint Dr. Charles E. Wall of Manitowoc, Dr. D. W. Dailey of Elcho, and Dr. O. G. Moland of Augusta. I should like to reappoint Dr. E. D. Sorenson of Elkhorn to serve as Chairman, and Dr. J. D. Leahy of Park Falls as Vice-chairman.

To the Commission on Public Policy: One term expires on this Commission. I should like to appoint Dr. J. M. Lubitz of Milwaukee, and reappoint Dr. R. G. Zach of Monroe as Chairman and Dr. W. T. Russell of Sun Prairie as Vice-chairman.

To the Commission on Scientific Medicine: One term expires, and I should like to appoint Dr. Edgar S. Gordon of Madison. This Commission selects its own Chairman.

To the Commission on Hospital Relations and Medical Education: There are three terms expiring. May I reappoint Dr. George B. Murphy of La Crosse, and appoint Dr. R. P. Fruehauf of Superior and Dr. G. W. Hilliard of Milwaukee. I should like to ask Doctor Murphy to continue as Chairman.

To the Commission on Public Relations and Communications: Three terms expire. May I reappoint Dr. J. S. Devitt of Milwaukee; Dr. Louis Olsman of Kenosha, and Dr. C. A. Olson of Baldwin. I should like to ask Dr. D. E. Dorchester to continue as its Chairman, and Dr. R. J. Botham to serve again as Vice-chairman.

Speaker Callan: Is there a motion to ratify these appointments?

Dr. L. O. Simenstad (Osceola): I so move.

(Motion seconded and carried.)

■ REPORT OF THE TREASURER—MAY, 1964

Dr. F. L. Weston (Madison): In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report. (The report appears on page 423 of this issue.)

■ REPORT OF THE STATE HEALTH OFFICER—MAY, 1964

Dr. Carl N. Neupert (Madison): It is a cherished privilege and an opportunity to accept your annual invitation to briefly present the affairs of the State Board of Health.

We are living in a period of rapid change—one of progress, that involves significant advancements in medicine and that calls for changes in concepts and responsibilities of the State Board of Health.

A year ago last February we started testing Wisconsin milk at six stations over the State for Iodine-131 from fallout from atmospheric testing of A bombs. We needed to know whether our milk contained enough radioactivity to threaten our infants' thyroid glands. These are activities in the field of Radiation Protection.

As you know, under provisions of the new State Radiation Protection Act we now have responsibility for annual registration of all medical and dental sources of ionizing radiation by way of x-ray equipment, and so on, as well as of industrial sources. Though this will probably change, currently 98 per cent of the registered sources are medical-dental as compared with 2 per cent industrial.

The long-term concern about radiation, whether it comes from fallout, from natural background radiation or from x-ray, radium, and so on, is the genetic effect on future generations. There is increasing recognition of the relationship between genetics and health, as indicated in our annual meeting program this year. There are the special presentations on medical genetics coming up on Tuesday and at our Public Health Round Table Luncheon on Wednesday.

Over the country there is increasing interest and concern over the adverse effects of air pollution on health. Deaths due to lung cancer are certainly rising rapidly in number, whether they are due largely to industrial and car exhaust pollution or to individual air pollution from cigarette smoking.

The Board has some additional responsibilities as of a few weeks ago as the result of having been designated by Governor Reynolds as the State agency to carry out the State's administration for construction of mental health and mental retardation facilities under the new Federal Construction Act. We will come to you for medical representation on the Advisory Committees and will work closely with the Mental Hygiene Division of the State Department of Public Welfare to assure a coordinated approach in this field. There is increasing involvement, as there needs to be, of practicing physicians in the prevention and treatment of mental illness and mental retardation.

One of the results of recent advances in modern medicine and public health is the recently announced extension of life expectancy to 78 years. Males are beginning to catch up with females, as reflected in gains in longevity among persons born after 1920. Greater gains for males reverses the trends of earlier generations.

As a result of these gains there are more and more older people in need of hospital and medical care. Tomorrow afternoon we will hear more about the new Wisconsin Health Assistance Payments Act to provide for such care.

Among the new statutory definitions in that Act is one defining a "skilled nursing home." Our law providing for licensure of nursing homes, as enacted in 1951, did not differentiate between nursing homes providing a skilled nursing service and those providing board and room for the aged. There is now need for such differentiation.

This has been recognized for some time. The Advisory Committee on Nursing Homes to the Board has been working on a major revision of nursing home rules for about a year. Doctor Stebbins, your representative on the Committee, has served conscientiously and well as its Chairman. There were many divergent points of view expressed by those in attendance at the three public hearings over the State on the proposed revisions of those rules governing nursing homes. Most of the proposals have been incorporated into the final draft adopted by the Board. They will be published as required and should become effective July 1, 1964.

They define (1) Homes for Skilled Nursing Care, (2) Homes for Limited Nursing Care, and (3) Homes for Personal Care, among other things. There will be regional meetings held to explain the new provisions prior to their becoming effective. I am sure you will find they do not go as far as some people would have liked them to, and farther toward

definite improvement than others would have preferred. Wait to see and study them before forming an opinion.

There are other evidences of this period of change, of progress, but time will not permit even touching on them. One thing we can be sure of—we will be moving forward together.

■ REPORT OF THE EXECUTIVE SECRETARY OF THE STATE BOARD OF MEDICAL EXAMINERS—MAY, 1964

Dr. T. W. Tormey (Madison): Since I last reported to you a year ago there have been some changes made in the Board membership. Two of us were replaced by new men, appointed for the customary four-year terms by the Governor. The new members are Dr. Ben Lawton of Marshfield and Dr. Matt McGarty of La Crosse. In view of the fact that the Board office is maintained in Madison, I have been retained as the Executive Secretary to look after the affairs of the Board and represent it on occasions such as this.

A number of new problems have presented themselves for consideration in this past year. Last July we had a most interesting meeting with about fifteen hospital superintendents, representatives of the Medical Schools and the Veterans Facility. The discussions centered around the problem of encouraging more graduate physicians to come to approved Wisconsin hospitals for their residency training programs. The thought was expressed that many potential resident physicians were lost because of the statutory requirement of licensure beyond the internship year—possibly not so much the need for a license as the objection to paying the required fee.

Following this and further discussion with other interested parties, a draft of a bill to be presented to the 1965 Legislature was prepared in cooperation with the State Medical Society. In essence the proposed bill will provide for licensure privileges in residency training to those qualified in the usual manner, on a $10 a year fee similar to the annual fee for the foreign medical graduate holders of the Temporary Educational Certificates. In this proposal the annual fee would be applied toward the usual and customary full licensure fee.

On a rough estimate this will cost us about $8,000 a year in revenue. Since we are a so-called self-sustaining Board and not receiving money from the general tax structure of the State, other funds will be necessary to carry on the routine work of the Board. It has been determined that the annual registration be set at $5—still a low figure compared to many states, and still only half of what is allowed by our statute.

A State Central Licensing Agency is being proposed (not by us), and a bill to make it a reality is in the legislative hopper. Under this bill all licensing bodies that have jurisdiction over physicians, dentists, nurses, veterinarians, plumbers, barbers, and so on, would be combined under the direction of one central agency. This was first conceived in one of the recent National Governors' Conferences.

A uniform Medical Practice Act is also visualized for all states. Since 43 states presently accept the certificates of the National Board of Medical Examiners as a basis for granting licenses, it is not difficult to imagine that were the remaining states to do so, the situation would be ripe for proposing that the local state boards be done away with and that a national licensing agency be established, with all the testing being done by the National Board.

As a matter of fact, at the Invitational Conference of the National Board in Philadelphia on March 13 this year, one individual suggested the time has come to do away with state boards. It has also been said the Committee on Licensure of the Association of American Medical Colleges has advocated that when a medical student graduates he should be licensed to practice without any further examination. These facts should be of some interest and concern to all of you.

One of the statutory conditions under which a license is issued to practice medicine and surgery in Wisconsin is that the Board receive "satisfactory evidence that the applicant has completed a hospital internship of at least 12 months in a reputable medical or osteopathic hospital." Under the discretionary and rule-making power granted the Board, it was decided years ago that a "reputable" hospital was one approved by the American Medical Association Council on Medical Education and Hospitals or by the like committee of the AOA for internship training.

We may have to change this rule because the number of such hospitals is steadily declining. It is true we accept a year of approved residency training in lieu of the internship as meeting this requirement. In Wisconsin the number of hospitals approved for internship has decreased from 22 in 1956 to 14 in 1963. On a national scale the hospitals approved for residency training have increased from 1,211 with 5,186 resident positions in 1956, to 1,474 with 37,610 resident positions in 1963. Isn't this an interesting indication of the trend toward specialization? Where are we going to get the much-sought-after general practitioners?

The foreign graduate physician is helping fill some of the needs of this State. Under our present law not more than 25 such individuals may be licensed in any year. Our quota potential is filled for this year and we are already trying to reserve numbers for 1965. I believe it is obvious that this phase of licensing will have to be revised in the interests of medical care.

You will be interested to know that of the 132 foreign graduate physicians licensed since January 1958:

69 are still in their original location
17 never did settle in Wisconsin
16 left the State
27 moved to another location in the State
3 have died.

Last year a total of 330 medical licenses were issued—

124 by written examination
206 after reciprocity interviews
Of this total 11 were females

Investigations of complaints were carried out in 1963, including:

14 M.D.s
6 D.O.s
12 quacks
2 chiropodists
3 chiropractors

To date the registration for 1964 includes:

4,533 M.D.s in the State
1,310 M.D.s out of State
239 D.O.s (total)
530 Physical Therapists (total)
181 Podiatrists (total)

The over-all total: 6,793 individuals.

I hope these remarks and figures have been of some interest to you, and I wish to express my thanks for the opportunity of appearing before you.

CES FOUNDATION ANNUAL MEETING. Trustees of the Foundation met Tuesday noon, May 12, for lunch and o business session. All officers were reelected for another year. They are pictured above left to right: Dr. G. J. Schulz, Union Grove, treasurer; Dr. A. J. McCarey, Green Bay, vice-president; Dr. W. D. Stovall, Madison, president; H. B. Maraney, Madison (staff); and Dr. Elizabeth Comstack, Arcadia, honorary vice-president. Not pictured is C. H. Crownhart, Madison, secretary.

■ REPORT OF THE ACTING DEAN—MARQUETTE UNIVERSITY SCHOOL OF MEDICINE—MAY, 1964

Dr. E. A. Bachhuber (Milwaukee): I would like to express my gratitude for the opportunity of presenting to you a short report on the present status of the Marquette University School of Medicine.

I don't suppose that our situation is unique, but we are in a period of great change and considerable unrest, and there are many decisions to be made which will have an impact upon the Marquette University School of Medicine of the future.

Although change does not necessarily mean progress, we are in the process of re-evaluating our educational objectives. A new block system has been integrated into our curriculum for the junior and senior years. There is greater emphasis on PhD programs in the basic sciences, in order to make our contribution toward providing teachers for the medical students of tomorrow. There is a cooperative effort between the medical school and the University in the area of the life sciences. There are plans for additional medical personnel to the staff, and a new Veterans Administration Hospital in the summer of 1965.

There has been a change in the Administration of the Medical School in the past year. In July 1963 Dean John S. Hirschboeck went on a leave of absence to devote full time to a planning project concerned with the Marquette Medical School of the future. The project is financed by the Hill Foundation of Minneapolis, Minnesota. Doctor Hirschboeck was succeeded by an armchair surgeon who is acting as Chairman of the Advisory Committee. In December 1963 Doctor Hirschboeck was appointed Vice-president and Secretary of the Marquette Medical School Corporation. A committee is actively searching for a new Dean.

New faculty positions are being created and chairmen are being recruited in certain departments to replace those who have been with us for many years. On June 30, 1964, Dr. Armand J. Quick will retire as Chairman of Biochemistry. Dr. Elston Belknap will retire as Professor and Chairman of the Division of Preventive Medicine and of the Department of Occupational and Environmental Medicine. We are attempting to recruit a Chairman for Occupational and Environmental Medicine in a new position that has been set up through the Allen Bradley Foundation which will emphasize industrial medicine, so important to this community.

A permanent Chairman for the Department of Psychiatry is sought. Dr. Richard O. Schultz, a full-time Chairman for the Department of Ophthalmology from the University of California, San Francisco, now at Jefferson, will succeed Dr. John Hitz.

Dr. Walter Gunn takes over as Chairman of the Department of Radiotherapy on July 1, 1964. There has been a movement to recruit faculty in the important areas of nuclear medicine and genetics.

A word should be said about students. At the present time we have 384 medical students, 146 medical technology students, and 88 physical therapy students registered in the Medical School. In the 1963 freshman class, 19 states and one foreign country were represented. The students came from 38 different schools—35 per cent from Marquette and 45 per cent from the State of Wisconsin. We have had more than 1,200 applications for the freshman class scheduled to enter in September 1964; this is 300 more than last year.

A five-year attrition study, 1958–1962, was carried out by Dr. Joseph Rastetter and his committee. In this period the academic failure record was 6.6 per cent, and the non academic dropout rate was 3.9 per cent, for a total attrition rate of 10.59 per cent, compared to a national attrition rate of 12.79 per cent.

The committee made an interesting observation, to the effect that the sons or daughters of physicians had nearly double the attrition rate of other students —that is, 20.7 versus 10.59 per cent.

As you may know, successful examination in Part I of the National Board of Medical Examiners is required for promotion from the sophomore to the junior year, and completion of Part II is required for graduation.

The amount of grant money for research, and to a lesser extent for training and teaching, continues to go up. It was over 2¼ million dollars for the last fiscal year, and will be considerably higher in the present fiscal year. Allen Bradley Medical Laboratories has been a big boost to animal research. A new addition to this Laboratory will probably become a reality in the near future. The faculty has contributed more than 300 articles and three monographs to the medical literature during the past year.

Twenty-five of our 99 graduates in June will intern in Wisconsin; 21 will stay in Milwaukee; 4 will intern in Marshfield; 8 at Milwaukee County Hospital, and 13 in the voluntary hospitals of the community.

At the instigation of Doctor Haukohl and through the Chairmanship of Dr. Joseph Devitt, a University Liaison Committee of the Milwaukee County Medical Society has been reactivated. A greater understanding of the economics and objectives of clinical practice in a medical school, better communication between medical school and medical community, do a great deal to combat the "town and gown" syndrome. It is much better to solve this problem now than to face it after a university hospital has become a reality.

When the medical needs of the State of Wisconsin indicate that another medical school should be built, we would welcome such a medical school to Milwaukee and would cooperate to the fullest to help establish it.

The Marquette University School of Medicine is undergoing great change, and is in a financial crisis not without turmoil and travail. It is a time for prudent judgment and wise decision. The cooperation and understanding of the medical community will help to establish a better Medical School today which will reflect itself in better doctors for tomorrow.

■ REPORT OF THE ACTING DEAN—UNIVERSITY OF WISCONSIN MEDICAL SCHOOL—MAY, 1964

Dr. James F. Crow (Madison): It is my honor and pleasure and especially my deep responsibility to serve the University of Wisconsin Medical School in the capacity of Acting Dean. I take this with great seriousness and regard it as an important service to the State and a responsibility that you and I share jointly.

I have enjoyed the most pleasant of associations with Marquette Medical School under Doctor Bachhuber. Wisconsin is perhaps the only state in the nation now that has two acting deans of its two medical schools.

This is my first and perhaps my last appearance before this august body. I should like to report some of the same kinds of things Doctor Bachhuber did. The kinds of enrollment trends that he reported for Marquette are also true for Madison.

For reasons beyond our understanding, the number of applicants for medical schools has gone up exponentially in the last few years. To quote a few random figures: We had approximately 200 applicants in 1952 for 80 positions. We had approximately 250 applicants in 1957 for 80 positions. The number of applicants went up to about 400 in 1962, to 600 in 1963, and is approximately 700 for the class that is coming in this fall, out of whom 100 will be accepted.

Of the class coming in this fall, 100 have been accepted definitely, including 92 males and 8 females. Twenty-two of the 100 are nonresidents of the State.

I think this is the best class of any recent year from the standpoint of grade point averages and test qualifications. Fifty-three of them come from the University of Wisconsin, three from the U. W. of Milwaukee, and the rest are scattered in other colleges. Fifty-five have entered with a bachelor's degree and some with higher degrees in addition.

As for the staff at the University, three of our outstanding positions have been filled during the year and one remains to be filled. The position in the Department of Surgery has been filled by Dr. Robert C. Hickey most admirably. The vacancy in Pharmacology has been filled by Dr. J. L. Strominger, who has now been on the campus for about six months. He has done some outstanding research in the nature of bacteria on the cell wall.

It is also a pleasure to announce that Dr. Nikolaus Mani, who has been visiting professor of the History of Medicine, has agreed to accept a permanent position in this Department. Doctor Mani brings a number of quite different attributes to this position. He is a well-known medical scholar and a very popular teacher.

We have one tragic loss to report. Dr. Sidney Orth's sudden death this year left us with an even more serious shortage in a department that is already understaffed. We also have two department chairmen resigning as of the end of the year—Dr. O. O. Meyer of the Department of Medicine and Dr. L. W. Paul of the Department of Radiology.

I would like to give you some data on budgets to emphasize the kind of trends that the University is faced with, which are part of a national trend. If we look at the expenditures of the Medical Center exclusive of the hospital, as of 1951, in that year about 80 per cent of the total cost of the Medical School, roughly $1 million, came from the State of Wisconsin. If we look at the corresponding figure for 1962–63, the State's contribution has increased substantially, but it now amounts to only about 43.68 per cent of the total assets of the Medical School; 43.68 per cent is paid by the State and now 46.37 per cent by the Federal Government, so the State is no longer the major tax support that the Medical School has.

I would also like to point out a rather similar trend in the buildings. In the buildings built between 1919 and 1940, the State of Wisconsin paid 87 per cent, the Federal Government paid 4 per cent, and the rest of it came from odds and ends of gifts. Nothing happened between 1940 and 1951. Of the buildings built between 1951 and 1963, the State of Wisconsin paid almost exactly one-half of the cost, or 49 per cent, the Federal Government paid 30 per cent, and the gifts remained about the same fraction. Of the buildings now under construction, the Federal Government is paying 82 per cent and the State is paying only 3 per cent. The implications are obvious.

I should think for yourselves and for other doctors in the State, that among your biggest problems, if not your biggest problem, is the tremendous increase in the rate of knowledge. I should think your biggest difficulty is to keep from becoming obsolescent. May I give you an example of unplanned obsolescence:

If I may carry over from general scientific knowledge to medical knowledge, I have read that the rate of increased publication approximately doubles every fifteen years. If I make the assumption that the number of words written is proportional to knowledge, and I agree this is a dubious assumption but let's accept it as a first approximation, this means that a person is only half educated fifteen years after he leaves medical school, and this assumes he remembers what he learned in medical school with 100 per cent precision.

I take it as the conclusion of these remarks that the field of postgraduate education is going to become more and more important; and this, may I suggest to you, is the major opportunity for a fruitful interaction between the State Medical Society and the medical schools of the State.

I have tried to institute studies leading forward to planning for a more extensive postgraduate medical education for the University. I don't want to say that very much has been done beyond the talking stage. We solicit your suggestions. We have the cooperation of the University Extension Service. I don't think it is quite proper for an acting Dean to move too far in an organizational direction with something like this, but I suggest this is one of our major needs—not only needs but challenges and real opportunities for the future.

NEW PRESIDENT. Dr. W. P. Curran, Antigo (left), was sworn in as president of the State Medical Society by Dr. James C. Fox, La Crosse (right), chairman of the Council, at the annual dinner festivities Tuesday evening, May 12.

The University of Wisconsin is a great University, we all agree. We are all proud of it. We are proud of our Medical School within the University. I suggest that a strong clinical-medical faculty, which we have, is a necessary condition for a strong medical school, but it is not a sufficient condition. We need even more than we have now—a high quality and imaginative teaching. We need to examine, even more than we are now doing, the curriculum and the ways in which the teaching is done. We also need first-rate research. We have some and we need even more.

Wisconsin has a proud heritage in all three aspects of teaching, service and research, and I look forward to an even brighter future.

■ REPORT OF THE COUNCIL—MAY, 1964

Dr. James C. Fox (La Crosse): Before reporting on the rather long agenda which the Council considered this afternoon, I will summarize actions of the March Council meeting, minutes of which have not been published as under Council procedures they are held for approval at the next ensuing meeting before publication in the WISCONSIN MEDICAL JOURNAL.

In March, the Council took action to defer elections to those offices within its jurisdiction until its meeting upon adjournment sine die of the House of Delegates.

It received a report from each councilor on activities within his district, an annual requirement.

The Council reviewed with satisfaction the most successful second Work Week of Health, and adopted a motion that the entire staff of the Society, from Secretary Crownhart across the board, be complimented for their perfect service, attention, and manners; and the Woman's Auxiliary was also thanked for its assistance.

At this meeting the Council reviewed in detail and approved for transmission to the House, the reports you have since received from the Commission on State Departments and seven of its ten Divisions; the Commission on Medical Care Plans; the Committee on Health Economics of American Life; the Committee on Grievances; the Commission on Public Relations and Communications; the Commission on Hospital Relations and Medical Education; the Committee on Cancer; and the Menominee County Study Committee.

In connection with the report of the Division on Nervous and Mental Diseases, Doctor Lorenz spoke to the Council on the broad subject of mental health laws and facilities, and the Council requested the Division to give further consideration to proposals that federal funds be utilized for postgraduate teaching in psychiatry for the general physician, and in the meantime approved financial support through Society mechanisms of circuit teaching programs to local practitioners.

The Council approved and has already forwarded to the House a bylaw amendment to increase the Commission on Scientific Medicine from five to ten appointed members.

At the March meeting the Council received a report from its Finance Committee and approved the operating budget for the current year.

It appointed John A. Kluwin, Milwaukee attorney, as associate Society counsel, and reappointed Robert B. Murphy as counsel, Donald E. Gill, consulting certified public accountant, and Carl A. Tiffany, consulting actuary.

It gave due commendation to E. M. Dessloch, M.D., retiring president of the SMS Realty Corporation, for his devoted service and fine performance in that office.

It approved a joint policy statement with the Wisconsin Nurses Association on closed chest cardiac resuscitation, and received a report from the Executive Committee that legal counsel and the American Medical Association legal department were being requested to prepare a statement relating the Wisconsin statute to pronouncements of the Judicial Council relative to the matter of surgical assistants.

It reports, in response to the request of the House in October, the following reimbursement policy for expenses of members in attending meetings of or in behalf of the Society, and, needless to say, this applies in instances where attendance is properly authorized:

Council: Pay expenses as billed for in-state or out-of-state meetings
AMA delegates and alternates: An allowance is established in the annual budget for each meeting attended
President: An allowance for in-state and out-of-state travel is established in the annual budget and reimbursement is made as billed
SMS committee members: Pay expenses as billed for in-state and out-of-state meetings
Commission on Medical Care Plans: WPS pays expenses billed for in-state and out-of-state meetings

Turning to its meeting this afternoon, the Council had a rather long agenda, and its meeting was preceded by meetings of its Executive Committee, Planning Committee, and Committee on Economic Medicine. Sometimes, gentlemen of the House, I wonder at the capacity of your councilors and officers to attend so many meetings and be in consideration of so many problems. Without counting attendance at any committee meetings, a councilor has to give up 12 or more days a year to carry out his duties.

However, my report is to endeavor to summarize briefly matters that are forwarded on to you for report or action:

First and foremost in importance, and I think you will understand why because you know my home town is La Crosse, is the invitation of the La Crosse County Medical Society to hold the Annual Meeting in the year of our 125th Anniversary in 1966 in La Crosse. Its facilities have been surveyed and found to be adequate, and I am happy to tell you that the Council recommends favorable action on this invitation . . . (Resolution No. 40 appears at end of this report.)

We will welcome you to La Crosse and we will provide you with an anniversary meeting that will stand out for all time.

Another recommendation of the Council is that we return to a Tuesday-Wednesday-Thursday scientific session, having exhibits arrive and be set up on Monday, avoiding the problems associated with securing help on Sunday at overtime rates for the exhibitors. Under this program the House of Delegates would hold its first session Monday night.

Another matter about which I am most happy to report is that the past presidents of our Society are now organized into a permanent committee to advise with us from time to time and in particular to develop detailed planning for events in 1966. The committee of past presidents, under the chairmanship of Doctor Curran, is planning many special events such as a dinner in Fond du Lac to commemorate the first president of the State Medical Society, Mason Darling, M.D., of that city. County societies are being written for their suggestions. The committee is calling on advice and assistance from the two medical schools and in due course as these plans are brought into final form, they will be reported to the House of Delegates.

Elections to the Commission on State Departments are reported to you as follows:

T. W. Tormey, Jr., M.D., Madison, General Chairman

L. M. Simonson, M.D., Sheboygan, Vice-chairman

and the following Division chairmen:

A. M. Hutter, M.D., Fond du Lac, Division on Aging

H. A. Anderson, M.D., Stevens Point, Chest Diseases

J. W. Nellen, M.D., Green Bay, Handicapped Children

John R. Evrard, M.D., Milwaukee, Maternal and Child Welfare

Charles Wunsch, M.D., Green Bay, Nervous and Mental Diseases

H. W. Carey, M.D., Lancaster, Public Assistance

Paul Dudenhoefer, M.D., Milwaukee, Rehabilitation

R. B. Windsor, M.D., Sheboygan, Safe Transportation

J. C. H. Russell, M.D., Fort Atkinson, School Health

Meyer S. Fox, M.D., Milwaukee, Visual and Hearing Defects

You will recall that the Commission on State Departments, a very active and a large organization, swings into action almost simultaneously with the conclusion of the Annual Meeting, and for that reason some years ago it was decided to announce the elections to the House at this time.

The Council recommends creation of a Section on Anesthesiology. There are approximately 100 members in this specialty. They have long desired a formal section, and the Council sees no reason to postpone action on that request.

There is a supplementary report from the Commission on Medical Care Plans which follows.

The Council forwards to the House a resolution offered by Doctor Collentine today relating to animal experimentation and federal legislation. (Resolution No. 42 follows this report.)

The Council forwards to the House without recommendation a resolution offered through Doctor Frank by the Eau Claire–Dunn–Pepin County Medical Society, relating to psychosis and other ailments. (Resolution No. 41 follows this report.)

I am happy to report to you for your information that Dr. R. L. MacCornack of Whitehall, one-time speaker of this House, has offered a resolution on alcoholism and a proposed state program in the care of the alcoholic. This resolution has been referred to the Planning Committee of the Council for study as to details, but in general by this report I want to indicate Council approbation of his fine efforts.

There were numerous other actions taken today which will be reported through the minutes of the Council as they appear in the Wisconsin Medical Journal, and I think while important, they are not of such concern as to burden you with a longer report.

The Council, however, does recommend that the House of Delegates be called into its interim session Friday and Saturday, October 9 and 10. For those of you who may have football schedules in your pocket, let me assure you that there is no home game in Madison that Saturday, and the Packers, of course, play on Sunday, by which time I would anticipate you will have adjourned sine die.

RESOLUTION NO. 40

Whereas: The State Medical Society of Wisconsin is composed of physicians from all parts of Wisconsin, including those from the western half of the State, and

Whereas: The annual meeting of the State Medical Society has not been held at La Crosse or a city outside of Milwaukee for several years, and

Whereas: The State Medical Society did meet in La Crosse, Wisconsin at one time, and

Whereas: The city of La Crosse is easily accessible by means of automobile, airplane, and train, and

Whereas: The city of La Crosse has motel, hotel, and restaurant accommodations capable of handling a convention of three thousand people plus an auditorium which seats four thousand persons, and

Whereas: The physicians of La Crosse County are desirous of having the State Medical Society hold their annual meeting in the city of La Crosse, therefore be it

Resolved, That the La Crosse County Medical Society do invite the State Medical Society of Wisconsin to have their annual meeting in La Crosse, Wisconsin in May of 1966.

RESOLUTION NO. 41

Whereas, Statute 49.18 (1) (b) and 49.20 (2) and 49.61 (1m) are unjust and discriminate against the unfortunate patient with a diagnosis of psychosis or tuberculosis, and

Whereas, Said Statute does not allow payment for services rendered to these patients in a private hospital, and

Whereas, Said Statute does not allow the doctor the right to treat his patient in the setting of choice, and

Whereas, Said Statute does not allow these patients the freedom of choice of physician or hospital, therefore be it

Resolved, That the State Medical Society of Wisconsin bring the problems that have arisen to the attention of the State Legislature and request that Bill 389 S be investigated and action taken to eliminate the abuse of both patients' and physicians' rights.

RESOLUTION NO. 42

Resolution Opposing Federal Regulations of Animals in Research

Whereas, The Wisconsin State Medical Society is an organization devoted to the advancement of medicine; and

WHEREAS, The Wisconsin State Medical Society meeting is concerned lest legislators unwittingly provide the means of impeding biomedical research through federal legislation, now being considered, which will regulate the use of animals,

WHEREAS, The bills contain no provision that recognizes the current needs of the field of laboratory animal care; and

WHEREAS, The implications made by proponents of such legislation that there is gross mistreatment of laboratory animals cannot be accepted; and

WHEREAS, The cost of governmental administration of such regulatory legislation could well be used to meet some of the current needs in the field of animal care; and

WHEREAS, Passage of these bills would probably result in even more oppressive legislative action; therefore, be it

Resolved, By the Wisconsin State Medical Society meeting in Milwaukee, Wisconsin, May 11, 12, and 13, 1964 that these restrictive bills inimical to scientific investigation be recognized as dangerous, insincere proposals, which if enacted, would not promote humane treatment of animals, but would seriously hamper and encumber scientific research. Furthermore, be it

Resolved, That the Wisconsin State Medical Society favors nonregulatory federal support of constructive measures to advance the care and treatment of laboratory animals; and be it further

Resolved, That the Wisconsin State Medical Society publicize this resolution and direct our Secretary to send a copy of this resolution to each of the senators and the representatives from Wisconsin, and to the sub-committees in the House and Senate to which these legislative proposals have been assigned, e.g., H.R. 8957.

SUPPLEMENTARY REPORT OF THE COMMISSION ON MEDICAL CARE PLANS—MAY 1964

Resolutions 1 and 2, October 1963 Interim Session, Introduced by Fond du Lac County Medical Society

These were referred to the Council and in turn to the Commission on Medical Care Plans for further study and report at the next meeting of the House.

At its meeting on April 18, 1964, the Commission approved the following recommendations with respect to these resolutions:

The first of the resolutions is premised on the assumptions that (1) there has been an ever-increasing tendency for the Welfare Department at all levels to become involved in the medical care of our citizenry; (2) over the years these activities have increased the demands, especially within the administrative duties of the medical profession, thereby adding materially to the overhead costs of providing certain phases of medical care; (3) there is no clear line of jurisdiction in many of these practices; and (4) the Welfare Department has in many cases assumed jurisdiction not provided by law.

Resolution No. 1 makes no effort to document the charges which, even if true at the local level, do not appear to justify reference to "the Welfare Department at all levels"—local, state and national.

The first section of the five-part Resolution No. 1 provides for instigation by the Council of "a thorough investigation of the relationship existing between the Welfare Department and the State Medical Society." It should again be noted that "Welfare Department" is referred to as though it applied to all welfare departments, at all levels and locations.

Resolution No. 1 would not appear to be justified on the basis of the generalities expressed, especially so if the cause of the complaints which prompt it arise out of misunderstandings at the local level.

In the absence of evidence that there is in fact justification for an investigation of the relationship existing generally between welfare departments and the State Medical Society of Wisconsin, it must be concluded that any problems should be resolved by the medical profession at the same level as that of the accused party.

The State Medical Society of Wisconsin should interest itself in problems of the Fond du Lac County Medical Society and its welfare counterpart only to the degree, if any, that the actions of the Welfare Department of Fond du Lac County are known to be dictated by the State Department of Public Welfare.

The commission recommends that the resolution be withdrawn and that the Fond du Lac County Medical Society be urged to meet with the Welfare Department of Fond du Lac County at the earliest possible date for the purpose of reaching agreement upon the respective places of individual medical practitioners and welfare department officials in administering programs for those eligible to welfare health benefits.

The second resolution is premised on the claim that "present financial arrangements and methods of payment for medical care of welfare recipients at all levels are generally unsatisfactory." Its purpose is to suggest that welfare recipients be provided with insurance contracts, thus taking the determination of benefits in individual cases out of the hands of welfare administrators.

The State of Texas is presently experimenting with such a system through Blue Cross and Blue Shield facilities, but no study has yet been made which would appear to warrant the conclusion that all of the problems of physicians with welfare departments are solved through it. Should the Texas experiment spread, as it well may, it is possible that the State Welfare Department of Wisconsin may consider some form of its adoption in this state. But for the State Medical Society of Wisconsin to "investigate the feasibility of offering a comprehensive coverage to the State of Wisconsin applicable to the medical care of welfare and relief recipients" would not presently appear to be justified on the basis of the known facts.

From the early discussion of this subject by the Council it is evident that many county medical societies are quite happy over the relationships they now enjoy with county welfare departments. It is the opinion of the Commission that the great majority of all county medical societies, and perhaps even all county societies other than Fond du Lac, would prefer the present system under which the professional fees of physicians are the subject of negotiation between county medical societies and county welfare departments.

The Commission recommends the withdrawal of Resolution No. 2 on the grounds that there is not adequate reason for its passage and on the further grounds that its acceptance would create in the minds of both county and state welfare administrators the mistaken impression that physicians are on a wide scale unhappy over the present system to the point where any element of negotiation should be removed by the substitution of an insurance device.

It should be noted in passing that a commercial insurance company will administer health benefits under the Kerr–Mills Act in Wisconsin. Until it is known what problems this may pose for county medical societies in particular, any extension of this approach to other segments of the population would appear to be inadvisable.

Resolution on Pathology and Radiology

One meeting has been held with representatives of pathology and radiology with reference to the resolution accepted by the House in May 1963 and referred to the Commission, relating to the inclusion of these specialty services under the medical service rather than the hospital service contract or rider. At that meeting it was agreed that each group would appoint two members to meet in further exploration of the matter with a committee of three from the Commission, named by its chairman.

The Commission reiterates that WPS has always recognized these services as the practice of medicine, as well as anesthesiology and psychiatry, and it is willing to discuss further how the services are to be compensated by the insurance plan, although there is strong feeling that this mechanism is not the proper way to correct the professional problem. To this date the two specialty groups have not advised of their appointments and a further meeting on the subject can not be held prior to the 1964 Annual Meeting.

Future Planning

Revision of the "A" scheduled contract

These benefits were established in 1952 and have since had no revision. The income level for full payment is argued as too low in light of wage level changes since that time. While the Special Service Contract meets both arguments and now constitutes the major percentage of WPS contracts, there are still substantial numbers of purchasers who desire a scheduled contract.

No new participation agreements would need to be secured inasmuch as the present agreement reads, in part:

> ". . . I agree that the Schedule of Benefits from time to time adopted or modified by the State Medical Society shall constitute the liability of the plans, as well as my maximum charges for professional services rendered under the plan for those within the applicable income limits."

The Commission has requested staff and consultants to submit recommendations looking toward revision of the "A" schedule, its full payment provisions, and certain unwieldy contract terminology, and established the interim meeting of the House of Delegates in October 1965 as a target date.

As to the "B" scheduled contract, WPS has for some time discontinued new sales—except for the Century Plan which incorporates it—and has made a concerted effort to upgrade "B" contract holders to "A" or Special Service. Wisconsin Plan companies are also in agreement that the "B" contract has outlived its usefulness as a service plan, and are not interested in improvement of the "A" contract.

Benefits for Nervous and Mental Diseases

The Commission is currently taking a close look at the future needs in the coverage of nervous and mental diseases.

There are now 20 general hospitals in Wisconsin which have psychiatric units. Fifteen years ago there were only two such units, due in part to the Hill–Burton program. It is felt that other large general hospitals will establish psychiatric units as soon as adequate staffing is available.

The length of stay in such facilities varies from 7.2 days to 34.1 days, with some indication of a trend to shorter lengths of stay. When compared to length of stay in state and county mental institutions, which may average from three to six months, one can easily conclude that the costs per admission would be more favorable in the general hospital, assuming the patient and physician have a choice.

In insuring against the costs of treating such illnesses, however, the Commission must look at other factors. Under the majority of WPS policies 120 days of institutional care is available for nervous and mental diseases, whether in a general hospital or a sanitarium. In a general hospital, however, the policies cover costs of miscellaneous items such as medications, nursing care, etc., in addition to room and board. In a sanitarium, coverage is limited to the room and board benefit. Furthermore, charges for psychiatric services are covered only when the patient is in a general hospital, with exceptions in the case of major illness policies. The Century Plan policy covers sanitarium care only when the patient is transferred from a general hospital.

The Commission is aware of activity by federal and state agencies in decentralizing care for mental patients on a local community level. There is, of course, always the concern that in doing so the controlling element will be retained in Washington since funds will, in large part, emanate from that source. It is axiomatic that when a need is not satisfied by private sources, government agencies are only to happy to fill it. Insurance coverage for the costs of treating mental patients must therefore be available in a proper manner and at a reasonable cost.

Historically, insurance has attempted to avoid extensive coverage of nervous and mental illnesses because of the concept of long-term custodial care in primarily government-operated institutions. As medicine has demonstrated that mental illness can be treated as effectively as physical illness, the insurance concept must be changed. The Commission notes that there are now 21 community mental health clinics in the state serving patients on an outpatient basis. There are, in addition, 35 county mental hospitals which are being pressured into becoming active treatment centers through recent enactment of legislation increasing the state's reimbursement formula.

The Commission has therefore asked the staff to present specific proposals in this area of coverage.

■ REPORT OF THE SECRETARY—MAY, 1964

Mr. Charles Crownhart (Madison): It is always a thrill for the Secretary's office to see the meeting come into being, for it brings into culmination the planning and gelling of some months. One cannot address the House of Delegates or the delegate caucuses or county meetings without an appreciation of the fine strength of medicine.

A year ago at this time I remarked on the fact that Charlotte Emmons was not here taking notes and coaching the Secretary and others on parliamentary law, and I also noted at that time the inability of Roy Ragatz to be here. Both of them are on deck this year, and I am sure a tribute is due to the high quality of medical care available under our free enterprise system.

It was in 1941, after the death of my brother, that I undertook the first series of attending caucus meetings. I was quite impressed at that time, and for some time after that, at the number of elder statesmen who appeared at the caucus meetings, having served with distinction, their hair just beginning to have a touch of gray; and I admired that kind of leadership.

Now, as I make the circuit, I am impressed with the fact that there seems to be a lot of younger men in the activities of the organization. I think that is fine. It shows that we have a mellow profession and that the median age of physicians is represented across the delegate line. I share the status of the older physician today; but it is nice, too.

I would like to extend to the staff (and there are many of them here) your appreciation as well as mine for the work they have done. Mr. Toser, as director of our insurance program; Roy Ragatz, as active as ever; and many new faces on the staff, all of whom have worked hard in connection with the meeting, and who I am sure share the same kind of pride in it that I do.

As Doctor Egan and Doctor Curran said, the state of the nation as represented by organized medicine in Wisconsin and in the country is excellent. There is renewed vigor in legislative activities and in the recognition of your responsibility to advise the public in what is proper in their health care.

We have concluded a legislative session, although we seem to have that with us rather constantly now; and the last word I have is that the Legislature, which convened in 1963, won't really adjourn sine die until about one minute before the new Legislature comes into being in 1965. While I am happy to have this House recognize its legislative function, and appropriately so, I hope it does not emulate the Wisconsin Legislature.

An announcement for you: On my lapel is a label which says, "I am Back of WISPAC; Are You?" At the conclusion of this session of the House of Delegates, and by request of Dr. Robin Allin, Chairman of AMPAC, a movie of an educational nature will be shown in this room. It is his hope as well as your Secretary's that you will find it possible to remain and see the movie, which runs for 23 minutes.

Tomorrow at 3:45 p.m. there will be a meeting, previously announced to you, arranged through cooperation with Doctor Callan, the Speaker. I think it is a distinguished and unusual opportunity for you to receive and for the staff also to receive first-hand information on the affairs to be administered under Kerr-Mills. I don't think Doctor Neupert mentioned in his talk to you that the State Board of Health is an advisory body in the implementation of Kerr-Mills, and certainly the enactment of that law could not have come about without your active support here in Wisconsin and the American Medical Association nationally.

I hope that every county medical society can be represented and will be able to get information back home promptly. Mrs. Emmons is going to transcribe that session of the House tomorrow, and she will do it in preference to the other three sessions. We will reproduce it and get it out to you at the earliest possible moment. Charlotte always cooperates with us.

The Council submitted a list of members and nonmembers who passed away during the year. The Secretary's office records another death since the list was prepared, that of *Alexander D. Spooner*, M.D., of Milwaukee.

(The House stood in silent tribute to their departed members.)

Speaker Callan: At this time the Speaker would like to introduce Mr. Thomas Redlin, sophomore, representing the Marquette Chapter of the Student American Medical Association.

Also, we have with us the officers of the Woman's Auxiliary to the State Medical Society of Wisconsin. May I call upon Mrs. W. D. James, of Oconomowoc, President of the Woman's Auxiliary.

■ REPORT OF THE PRESIDENT, WOMAN'S AUXILIARY—MAY, 1964

Mrs. W. D. James (Oconomowoc): When I appeared before you last October I told you briefly of the aims and projected program of the Auxiliary to the State Medical Society of Wisconsin. Now it is time to appear before you again, this time to report on the progress of that program.

MRS. W. D. JAMES
President
Woman's Auxiliary

MRS. J. J. SATORY
President-Elect
Woman's Auxiliary

As in all human endeavor, our accomplishments have in many instances fallen short of our aims. The year has been marked by times of satisfaction with work well done and projects successfully completed, and also by disappointment because of goals unfulfilled.

As I told you last fall, because we believe in the Auxiliary, its aims and its program, one of our major purposes during the past year was to set it onto the path of sound and continued growth. We had a total of 33 organized county groups out of a potential of 54. To narrow that gap between present status and potential, we took the following steps:

We contacted by letter the doctors' wives in all of those unorganized counties where we were able to get their names from the secretary of the county society. We told them of the program of the Auxiliary and invited them to become members-at-large. We have increased our membership-at-large from fewer than ten to forty-one.

We are proposing a change in our Bylaws to permit an auxiliary to organize in conjunction with another county when such a course seems desirable because the membership is small.

We have met with groups from three unorganized counties to explain the purpose and program of the Auxiliary. We hope that this effort can be extended and that several new groups will be organized in the not too distant future.

Our total membership this year is 1,858.

While an increase in membership is important, what is accomplished by that membership is even more important. This year those 1,858 members in the thirty-three organized county auxiliaries have contributed a total of $6,348.73 to the American Medical Association's Education and Research Fund. (This marks an increase of $1,139.64 over previous contributions.) This money was raised by the county units in a variety of ways—formal dances, cocktail parties, a benefit concert by an auxiliary member, community Christmas cards. One county made $100 by saving trading stamps. As always, where women are raising money, there were bake and rummage sales, and one county reported using the direct approach in their project: They asked their husbands for the money.

According to the report of the Scholarship Chairman, your Auxiliary is contributing $12,000 toward the expenses of 77 students enrolled in nursing schools throughout the State. One small auxiliary of less than twenty members living in widely scattered communities has a scholarship fund this year of $1,100. Another group, by sponsoring a style show to which community attendance was limited only by space, raised $2,800.

To further interest in health careers, beside giving this financial help, we sponsor 45 Health Career Clubs in high schools around the State.

The nine counties who this year were active in the relatively new program of International Health report sending more than a ton of supplies—sample drugs, books, journals, old sheets and shirts, leper bandages and small medical equipment—to World Medical Relief, Inc. and to various mission groups.

In addition to our annual budgeted contribution to the Society's CES Foundation, we have this year undertaken Operation Christmas Card, under the direction of the Society's staff.

Please note the display in the art booth at the Auditorium, and also please note that the members in charge are supplied with order blanks.

To assist the Society in its legislative program, our members have taken an active part. As an example, one county was responsible for 500 letters to various congressmen; another arranged fifteen speaking dates for local doctors on King-Anderson legislation; many helped with Operation Hometown; one sponsored a film and discussion for lay groups in their area.

Time does not permit me to tell you of the many community service projects reported, but let me list a few:

Fourteen auxiliaries helped with Sabin on Sunday; several staff the blood banks in their area; twenty-seven counties were active in mental health projects. There were projects to aid the aged, the retarded children, and the blind.

Our national theme this year has been SERVE AND COMMUNICATE. I have told you of some of the areas in which your Auxiliary has served. We have also made a sincere effort, wherever the opportunity arose to communicate in the interest of medicine, with lay and allied professional groups. I have represented the Auxiliary at meetings and on the program of several State women's groups, and have attended conferences in special fields.

State chairmen have attended conferences with other groups in their area of interest. We have planned cooperative projects with groups whose interests parallel ours. It is our hope that this will lead not only to greater accomplishment but also to better community understanding of medicine's concern for the welfare of all people.

I would like to take this opportunity to thank the Society, its officers and the staff, both for the Auxiliary and for myself, for the help you have given us and for the many courtesies you have extended. Your kindness is sincerely appreciated. And my own special thanks to the Councilor from the First District for his patience, encouragement and loyal support.

Because this convention marks not only the end of an Auxiliary year but also the launching of a new year, when new hands will take up the old tasks and new programs will be inaugurated, I would like to present to you now the one who will lead your Auxiliary in the year ahead. Our President-elect, Mrs. John Satory, of La Crosse.

■ SUPPLEMENTAL REPORT OF THE SURVEY STUDY COMMITTEE—MAY, 1964

Dr. Joseph C. Griffith (Milwaukee): The Survey Study Committee was originally directed by this House of Delegates to review and study the Survey and make appropriate recommendations in the form of resolutions to the House of Delegates at the next annual meeting of this House. The Committee made a partial report at the interim meeting in October 1963, at which time the House of Delegates ordered that the Survey Study Committee be continued for another full year.

MEDICAL ART SALON WINNERS

OILS

First place—"*View Swissair*"—Mrs. Marvin Wells, Milwaukee

Second—"*Coal Dock*"—Victor F. Neu, M.D., Green Bay

Third—"*Dark Passage*"—A. M. Gottlieb, M.D., Madison

Honorable Mention:

"*Mountain View*"—M. G. Gutglass, M.D., Milwaukee

"*San Miguel de Allende*"—Sheba Jacobson, Milwaukee

"*Untitled*"—Diane Healy, Madison

WATER COLOR

First—"*Milkweed, etc.*"—Barbara Ragers, Oconomowoc

Second—"*Factory*" — Mrs. Kinge Hara, Milwaukee

Third—"*Street Scene, Paris Sacre Coeur*"—Mourice Hardgrave, M.D., Milwaukee

Honorable Mention:

"*Abandoned Mill*"—Julie Kilpatrick, Madison

SCULPTURE

Honorable Mention:

"*Beach Scene*"—Mrs. B. J. Malnekoff, Milwaukee

POPULARITY VOTE

Intermission" (oil)—A. M. Gottlieb, M.D., Madison

BEST IN SHOW

"*Vilas County*" (oil)—William Havis, M.D., Milwaukee

VIEW SWISSAIR

VILAS COUNTY

Top—MILKWEED, ETC.
Bottom—EGGS, ETC.

This was a special annual meeting feature sponsored by the Woman's Auxiliary. Co-chairmen were Dr. and Mrs. Jack Teasley and Dr. and Mrs. Milton Gutglass, Milwaukee.

Exhibits were accepted in sculpturing and painting (watercolor and oil). Any member of the State Medical Society or his wife were eligible.

This was the third year of the salon whose popularity has increased significantly each year. There were more than 75 entries this year.

The salon has became a popular "coffee break" area and hospitality center.

At a recent meeting of the Survey Study Committee a legal question arose as to whether the House of Delegates has the authority to direct by resolution the method or manner in which the Council, as a Board of Directors, carries out its duties under the non-profit, non-stock corporation law of the State of Wisconsin.

The Committee felt uncertainty as to the respective authority and functions of the House of Delegates and the Council with respect to certain of the recommendations contained in the Booz-Allen-Hamilton report, and more generally in the relationship of those two bodies in the operation of our Society.

The Survey Committee officially authorized its Chairman and Vice-chairman to obtain the opinion of independent legal counsel to clarify these basic questions. The firm of Quarles, Herriott and Clemons state that the State Medical Society was chartered under the territorial laws of 1841 which sanctioned our original Constitution and Bylaws, and the general law passed later, covering non-stock corporations, is not to be construed as amending or affecting our Constitution and Bylaws. There are certain fundamental rights inherent in the original charter dating back to 1841.

According to their opinion, the House of Delegates is the official legislative body of the Society, and the House alone has the power to amend the Bylaws. It would follow that it, the House, may offer any directions for the conduct of the Society that it decides upon, if not by resolution at least by change in the Constitution and Bylaws.

This legal opinion is submitted for your information relative to these and future resolutions offered. A copy of the full legal opinion rendered by Quarles, Herriott and Clemons is in the possession of all chairmen of reference committees as well as all members of the Survey Committee should you desire detailed information.

It is further recommended that this opinion be placed on file along with the official transactions of this annual meeting of the House of Delegates.

REFERRAL OF RESOLUTIONS AND REPORTS

Speaker Callan: The Speaker wishes to announce the following referral of resolutions and reports. So that the delegates may be advised as to which reference committee will hear the various reports and resolutions submitted, this announcement is made upon the subject. Where the subject matter is related, your Speaker has made every effort to refer those matters to the same reference committee.

Reference Committee on Resolutions:

Report No. 2—Commission on Medical Care Plans.
Survey Study Committee Report—Resolutions 1 through 22 and statement on the Blue Shield Plans.
Resolutions 26 through 31—Bylaw revisions forwarded by Council.
Constitutional amendment re special sessions of the House is referred for formal presentation at this annual session, but action may not be taken until 1965.
Resolutions 32 and 33—Milwaukee County re Survey.
Resolutions 36 and 39—Milwaukee and Wood County re Civil Rights.
Resolution 37—Milwaukee County re group disability plan.
Location of 1965 Annual Meeting.

Reference Committee on Reports of Officers:

Report No. 1 and 1-A to G—Commission on State Departments.
Report No. 8—Menominee County Study.
Resolution 25—Waupaca County re Mobile Units.
Resolution 35 — Milwaukee County re Doctor Egan.
Report of Treasurer and Audits.
Necrology and Membership Reports.

Reference Committee on Reports of Standing Committees:

Report No. 3—Health Economics of American Life.
Report No. 4—Grievance.
Report No. 5—Public Relations and Communications.
Report No. 6—Hospital Relations and Medical Education.
Report No. 6—Cancer . . . also Resolutions 23 and 38 re cigarette smoking.
Resolution 24—Manitowoc County re Hospital Bylaws.
Resolution 34—Milwaukee County re King-Anderson.
Commission on Public Policy re Health Fads and Fallacies Conference, which has been distributed to the House.

It is a privilege as well as an opportunity for any interested member of the Society to appear before these committees and present his views on any matter properly before them. Delegates who are interested in any particular matter are especially urged to be present.

At this time we proceed to the selection of a Committee on Nominations. Mr. Secretary, will you please announce the caucus arrangements.

Secretary Crownhart: The delegates of each District, many of whom have not caucused on their selection as yet, should remain at their places. The House will recess for a brief period of time and then will be called back to order. You will then report your selection for the Committee on Nominations.

AMA–ERF CONTRIBUTIONS

Speaker Callan: At this time the Chair will call upon Doctor Blanchard, who has a pleasant duty to perform.

Dr. P. B. Blanchard (Cedarburg): Each year Wisconsin physicians, through the American Medical Association's Education and Research Foundation, make contributions to help support medical education.

As Wisconsin Chairman for the AMA-ERF, it gives me great pleasure to present the 1963 contributions to the Acting Deans of our two medical schools.

These grants may be used at the discretion of the Acting Deans for regular budgetary needs or for special programs and projects which might not otherwise be possible.

To Marquette University School of Medicine, here is a check for $18,129.04.

To the University of Wisconsin Medical School we present a check for $8,910.46.

On behalf of the AMA-ERF I would like to thank the physicians of Wisconsin for their continued support of this fine program.

Speaker Callan: Before we go on with the selection of a Nominating Committee, the Chair would like to complete the referral of reports. The Council's report will be referred to the Reference Committee on Reports of Officers, except the Supplemental Report of the Commission on Medical Care Plans and Resolution No. 40, which will go to the Reference Committee on Resolutions.

Resolution No. 42, having to do with Animal Experimentation, will be referred to the Reference Committee on Standing Committees.

COMMITTEE ON NOMINATIONS

Speaker Callan: Mr. Secretary, will you call the roll of Districts, and will each District respond by announcing its nominee for the Committee on Nominations.

(The following nominees were presented from their respective Districts to the Committee on Nominations:)

Committee on Nominations

First District _____ Robert Monk, M.D.
Second District _____ V. J. Burch, M.D.
Third District _____ H. M. Suckle, M.D.
Fourth District _____ W. D. Hamlin, M.D.
Fifth District _____ E. C. Quackenbush, M.D.
Sixth District _____ David Twohig, M.D.
Seventh District _____ David Morris, M.D.
Eighth District _____ J. W. Boren, Jr., M.D.
Ninth District _____ E. C. Glenn, M.D.
Tenth District _____ L. O. Simenstad, M.D.
Eleventh District _____ C. J. Picard, M.D.
Twelfth District _____ P. G. LaBissoniere, M.D.
Thirteenth District _____ J. D. Leahy, M.D.

Speaker Callan: The Chair will entertain a motion that these nominees constitute the Nominating Committee.

Dr. E. L. Bernhart (Milwaukee): I so move.

(Motion seconded and carried.)

Speaker Callan: I would like to remind the House that after adjournment Dr. Robin Allin, of the HEAL Committee, will present a very interesting and educational film in this room, and of course everyone is invited to view it.

There being no further business at this session, a motion for adjournment is in order.

Dr. E. D. Sorenson (Elkhorn): I move we adjourn.

(Motion seconded and carried.)

MONDAY EVENING SESSION

May 11, 1964

REPORT OF CREDENTIALS COMMITTEE

Doctor Carlson: The Committee on credentials has verified the registration of 69 delegates and 7 alternate delegates entitled to vote at this session of the House of Delegates. This represents forty county medical societies and seven sections.

I move that the attendance role of delegates, alternate delegates and specially appointed delegates, totaling 76, so compiled by the Credentials Committee, be accepted as the official roll of this session.

(Motion seconded and carried.)

■ REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Re: Committee on HEAL

Dr. F. E. Gehin (Stevens Point): Your Reference Committee on Reports of Standing Committees has reviewed the report of the Committee on Health Economics of American Life and also heard testimony from Dr. Robin Allin, its Chairman, during the Committee hearing.

It has been pointed out that this Committee was formed in 1959 particularly to meet the emergency situation created by federal legislation dealing with health care for the aged; that the emergency still is very much in existence and promises to be for some time to come. Doctor Allin reminded us that the King-Anderson bill or a similar model may come out in Congress, and that we should be prepared for rapid action, especially through the "Operation Hometown" program.

Your Reference Committee urges you to heed the main concern of the Committee, which is that organized medicine's position on King-Anderson be transmitted to the public, and to have the public and profession in turn make this position known in Washington.

Your Reference Committee recommends acceptance of the report as presented to the House, and I so move.

(Motion seconded and carried.)

Re: Resolution 34

Doctor Gehin: Your Reference Committee studied resolution 34, introduced by the Medical Society of Milwaukee County, relating to the King-Anderson bill, and after hearing testimony this morning offers the following substitute resolution:

WHEREAS, the King-Anderson bill, H.R. 3920, 88th Congress, and similar legislation would establish a compulsory and unnecessary federal health care program for persons over age 65 regardless of need, and

WHEREAS, the King-Anderson bill represents a multi-billion dollar tax increase and does not provide what its propagandists promise, and

WHEREAS, the enactment of the King-Anderson bill would result in definite curtailment if not the ultimate wrecking of existing and rapidly expanding voluntary health insurance plans and other agencies, and

WHEREAS, in those states where existing federal law, the Kerr-Mills Act, is operational AS INTENDED, it has been proven to be a sound and workable program that provides comprehensive medical care for old people who need it, and

WHEREAS, existing deficiencies of the Kerr-Mills Act can be readily corrected by simple amendments prescribing a minimum schedule of benefits to be paid by participating states and devising standards for measuring need, and

WHEREAS, it is the sincere conviction of the physicians of the State of Wisconsin that passage of the King-Anderson bill would result in a lower standard of health care for the American people; now, therefore, be it

Resolved: That the State Medical Society of Wisconsin reaffirm its position of unequivocal opposition to the King-Anderson bill and any similar legislation.

I move adoption of this substitute resolution.

(Motion seconded and carried.)

Re: Committee on Grievances

Doctor Gehin: Your Reference Committee has reviewed the report of the Committee on Grievances and agrees that issues before it should be resolved by answering the questions on individual facts presented, and applying the principles and official interpretations of the American Medical Association. Questions concerning professional courtesy for dependents of physicians should also be considered on this basis. Your Reference Committee recommends acceptance of this report.

(Motion seconded and carried.)

Re: Commission on Public Relations and Communications

Doctor Gehin: Your Reference Committee has reviewed the report of the Commission on Public Relations and Communications, whose work has dealt with extending communications especially by television and radio facilities, on matters relating to

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES. Left to right: Dr. G. W. Hilliord, Milwaukee; Dr. W. T. Russell, Sun Proirie; Dr. F. E. Gehin, Stevens Point, choirmon; Dr. C. A. Grand, Ashlond; ond Dr. W. F. Henken, Racine.

health. It has developed a program series on Health Fads and Fallacies which is being offered to television stations in the State as a public service series. The Commission has also been in liaison with rural organizations, especially with 4-H Clubs, and 54 Clubs were presented special certificates and subscriptions to TODAY'S HEALTH in 1963.

The Commission has also worked closely with the Wisconsin State Medical Assistants Society in its effort to improve the educational level and job efficiency of medical assistants.

Your Reference Committee agrees with the comment of the Commission that polio immunization programs of county medical societies have been valuable public relations efforts.

The Reference Committee concurs with the recommendation of the Commission that a more effective liaison with county medical societies should be developed by having each county medical society appoint one member to serve as the local contact with the Commission concerning State-level planning and as a recipient of information for use in local public relations programs.

Your Reference Committee recommends approval of the report of the Commission as presented to the House, and I so move.

(Motion seconded and carried.)

Re: Commission on Hospital Relations and Medical Education

Doctor Gehin: The report of the Commission on Hospital Relations and Medical Education has been reviewed by the Reference Committee.

An oral presentation by its Chairman, Dr. George B. Murphy, indicated that there is a desire to have the Commission divided into two parts, one on hospital relations and a separate Committee on Medical Education so that the functions may be performed more efficiently, and to encourage the academic men to attend meetings especially devoted to medical education.

Your Reference Committee recommends that the question of committee structure be referred to the Council for consideration, and the written report of the Commission be accepted.

I so move.

(Motion seconded and carried.)

Re: Committee on Cancer

Doctor Gehin: The report of the Committee on Cancer was studied by your Reference Committee, and it notes that the Cytology Service Program of the State Laboratory of Hygiene has not been supplemented fast enough by private programs in the State, and as a result too small a percentage of women are being checked by the cytology smear.

Your Reference Committee wishes especially to note agreement with the position of the Committee on Cancer that research and treatment programs which have been initiated and recommended by the American Cancer Society and other bona fide national voluntary health agencies are preferable to a non-specific approach to illnesses of the whole man.

In connection with this report, your Reference Committee reviewed resolution No. 23 submitted by the Committee on Cancer, and resolution No. 38 submitted by the Medical Society of Milwaukee County. Since both resolutions pertain to the same subject, your Reference Committee recommends adoption of resolution No. 23 by the Committee on Cancer, and I so move.

(Motion seconded and carried.)

Re: Resolution No. 24

Doctor Gehin: Your Reference Committee considered resolution No. 24 introduced by the Manitowoc County Medical Society. After reviewing all the testimony presented at the hearing, your Reference Committee recommends that this resolution be referred for further study by the Commission on Hospital Relations and Medical Education and by the legal department of the State Medical Society. I so move.

(Motion seconded and carried.)

Re: Resolution No. 42

Doctor Gehin: Your Reference Committee reviewed resolution No. 42 introduced by the Council with reference to federal regulations of animals in research, and finds it consistent with a similar resolution adopted by this House last year.

Your Reference Committee recommends adoption of resolution No. 42. I so move.

(Motion seconded and carried.)

Re: Commission on Public Policy

Doctor Gehin: Your Reference Committee studied the report of the Commission on Public Policy covering the Conference on Health Fads and Fallacies held last month in Port Edwards.

We recommend acceptance of the report and approval of a one-day conference in the Fox River Valley next year, and wish to commend the Commission for its excellent work. I so move.

(Motion seconded and carried.)

Doctor Gehin: I now move adoption of this report as a whole.

(Motion seconded and carried.)

INTRODUCTION OF GUEST

Speaker Callan: At this time I have the privilege of introducing a special guest, Dr. John Medelman, President of the Minnesota State Medical Association. Doctor Medelman, will you say a few words?

Dr. John Medelman: I would be delighted to say just a few words. It is an honor to meet with your House of Delegates. It is a great pleasure to be here with Otis Simenstad and some of these men I have known for years.

I would like you to accept the greetings of the Association which I represent.

■ REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Re: Resolutions Nos. 1, 3, 4, 5, 6, 7, 11, 17, 18, 19, 20

Dr. T. J. Nereim (Madison): In open hearing this morning and in executive session this afternoon, your Reference Committee on Resolutions reviewed the large number of items referred to it. The following resolutions of the Management Survey Study Committee appeared either to involve no essential change in present procedures or to consist merely in amplifying duties of officers, and your Reference Committee recommends their acceptance.

Resolution No. 1, dealing with the programs of the Society.
Resolution No. 3, dealing with assistance to county medical societies.
Resolution No. 4, dealing with relations with other professional groups.
Resolution No. 5, dealing with community health programs.
Resolution No. 6, dealing with physician education programs and non-medical aspects of practice.
Resolution No. 7, dealing with program appraisals and membership surveys.
Resolution No. 11, dealing with the duties of the presiding officer and Secretary.
Resolution No. 17, dealing with selection of officers.
Resolution No. 18, dealing with the duties of the President.
Resolution No. 19, dealing with the duties of the President-elect.
Resolution No. 20, dealing with the duties of the Speaker and Vice Speaker.

I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 2

Doctor Nereim: Resolution No. 2, submitted by the Management Survey Study Committee, dealing with Field Services, recommends continuation of the program, and that the Council submit a report on the scope of activities and costs at the 1964 interim session of this House. Your Reference Committee recommends adoption of this resolution. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 8

Doctor Nereim: Resolution No. 8, of the Survey Study Committee, regarding tenure of delegates, recommends that Section 8, Chapter XI of the Bylaws be amended to provide that the minimum term of delegates to the State Medical Society shall be for two calendar years. Your Reference Committee recommends adoption of this resolution. I move acceptance of this portion of the report.

(Motion seconded.)

Speaker Callan: Since this would be a Bylaw amendment, a two-thirds vote is required. All those in favor of Resolution No. 8, please rise.

Dr. G. E. Collentine, Jr. (Milwaukee): I believe a resolution so offered has to lie over for one day.

Speaker Callan: It was presented last night with the report of the Survey Committee. It has lain over. That has already been checked out with legal counsel.

All those opposed to Resolution No. 8 as proposed, please rise.

(Motion carried.)

Re: Resolution No. 9

Doctor Nereim: Resolution No. 9 of the Survey Study Committee, regarding scientific sections, recommends that the scientific sections in the House of Delegates continue with their present structure pending further study by the ad hoc committees of the State Society and the American Medical Association. Your Reference Committee recommends adoption of this resolution without prejudice to the addition of future scientific sections. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 10

Doctor Nereim: Resolution No. 10, also of the Survey Study Committee, listing five duties appropriate to the maintenance of strong relationships with their component societies, is one in which your Reference Committee concurs and recommends for adoption. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 12

Doctor Nereim: Resolution No. 12 of the Survey Study Committee, deals with reference committees, their appointment and assignments delegated to them. Your Reference Committee recommends adoption of this resolution as presented. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 13

Doctor Nereim: Resolution No. 13 of the Survey Study Commitee deals with the election of candidates for Councilors. Your Reference Committee noted the difference between this resolution and that portion of Resolution No. 32 of Milwaukee County dealing with the same subject, but recommends the adoption of Resolution No. 13 as submitted by the Study Committee. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 14

Doctor Nereim: Resolution No. 14, submitted by the Survey Study Committee, relates to Councilor terms and limitations. Your Reference Committee recommends adoption of this resolution and notes that since it requires an amendment to the Constitution, the matter must be laid over for action at the May 1965 annual meeting. I move acceptance of this portion of the report.

(Motion seconded.)

Dr. B. P. Waldkirch (De Pere): Would the Chairman of the Reference Committee please explain how the phrase "wherever possible" is interpreted, and by whom it is to be interpreted?

Speaker Callan: I will refer the question to Doctor Nereim.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS. Left to right: Dr. L. W. Schronk, Woupun; Dr. C. J. Picord, Superior; Dr. E. P. Rohde, Golesville; Dr. D. R. Griffith, Eau Cloire; Dr. G. E. Collentine, Jr., Milwoukee; Dr. T. J. Nereim, Madison, chairmon; ond Dr. G. A. Behnke, Koukouna.

Doctor Nereim: This term stimulated considerable discussion in our Reference Committee, and it was debated whether we should delete it or leave it in. It was decided to leave it in so as to perhaps make it more acceptable.

Doctor Waldkirch: My question is: Who is to interpret the phrase if it comes up?

Doctor Nereim: The House of Delegates.

(Motion carried.)

Re: Resolution No. 15

Doctor Nereim: The Study Committee's Resolution No. 15 deals with appointments to Council committees by the Chairman of the Council, and your Reference Committee recommends that it be referred back to the Study Committee for further study and clarification. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 16

Doctor Nereim: Resolution No. 16 of the Survey Study Committee, dealing with procedures to improve Council meetings, was considered in some detail. Testimony in open session indicated that most of the suggestions made are at present being carried out, and the Reference Committee wishes to commend the Council and the staff for their efforts. Although your Reference Committee feels that the estimate of the additional cost is excessive, it recommends adoption of this resolution. I move acceptance of this portion of the report.

(Motion seconded.)

Dr. J. G. Bergwall (Hortonville): At the morning session there was some controversy about this resolution. If the Speaker will not speak as he did this morning, would somebody else please explain the point I brought up this morning, namely, the problem of delegation of authority, about which I personally did not receive an explanation?

Speaker Callan: Are you inquiring as to the authority of the House of Delegates to instruct the Council?

Doctor Bergwall: That is correct.

Speaker Callan: The Speaker would like to call on the Chairman of the Special Survey Committee, Dr. Joseph Griffith, if he is present, for a brief explanation.

Dr. D. R. Griffith (Eau Claire): The Study Committee has been faced with somewhat of a difficult problem. In the Constitution and Bylaws of the State Medical Society the duties of the Council are pretty well spelled out. In the Booz, Allen & Hamilton report many recommendations are made as to the conduct of the Council, its reorganization, and reorganization of the State Society office.

In resolutions such as the one under discussion there is some question as to whether the House of Delegates, in a session such as this, may offer directions to the Council of the State Medical Society concerning how to conduct the Council's business.

Under the nonstock, nonprofit law of the State of Wisconsin it would seem that a Board of Directors, which is the Council of our Society, has the authority to do what they choose in the conduct of their business. However, in analyzing the authority in the State Society, it has the authority, according to special legal opinion that we have obtained, to direct the State Medical Society by a change in the Constitution and Bylaws. This House is the only one that has the authority to do this.

This particular resolution was offered to the House of Delegates as a framework to improve the efficiency of the Council. I don't think it is very important as far as this resolution is concerned, but it is important as far as some of the other chapters this Committee still has to study is concerned; for instance, as far as the Council committee structure is concerned, people they hire, and other things they do, and how they do it.

We presume the Council is a board of directors in the interim between sessions of this House of Delegates and should be given considerable latitude; but when the authority of the House of Delegates is questioned, our Committee wondered whether it was true that the House should have any authority over the Council. The legal opinion we received was that the House of Delegates is the legislative body and has the authority, if it chooses to exert it, of the State Medical Society.

(Motion carried.)

Re: Resolution No. 21

Doctor Nereim: Resolution No. 21, again one of those submitted by the Survey Study Committee, deals with the elimination of existing restrictions on participation of nonsociety members in society programs. After thoughtful review your Reference Committee recommends adoption of this resolution. I move acceptance of this portion of the report.

(Motion was put to a vote.)

Speaker Callan: The Chair is in doubt.

Dr. J. F. Walsh (Port Washington): I move that a secret ballot be taken on Resolution No. 21.

(Motion seconded and lost.)

Dr. S. E. Zawodny (Milwaukee): What does Robert's Rules of Order say about a secret ballot?

Speaker Callan: The motion has to be carried by the delegation. If the delegation requests it and votes for it, it is perfectly in order. The Chair has no authority to order a secret ballot. We are at a stalemate as to how to dispose of this resolution.

Dr. R. N. Allin (Madison): I move a roll call vote.

(Motion seconded and carried.)

SUPPLEMENTAL REPORT OF CREDENTIALS COMMITTEE

Doctor Carlson: Then I presume you will want a supplemental report of the Credentials Committee.

Speaker Callan: Yes. May we have that now, Doctor Carlson.

Doctor Carlson: In addition to those delegates already registered and reported on by the Committee on Credentials, 14 delegates and 4 alternates have been registered and are entitled to vote.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 94, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

Speaker Callan: The Secretary will call the roll.

Dr. G. S. Kilkenny (Milwaukee): May I call for a ten-minute recess to caucus. I so move.

Doctor Bergwall: Second the motion.

(Motion lost.)

Speaker Callan: The roll call vote is on the adoption of Resolution No. 21. The Resolved portion reads:

> "That the existing restrictions on participation of non-society members in Society programs be eliminated."

The Secretary will call the roll.

(Secretary Crownhart called the roll and the vote was as follows:)

Society	Delegates and Alternates	Yes	No
Ashland–Bayfield–Iron	C. A. Grand	x	
Barron–Washburn–Sawyer–Burnett	C. J. Strang	x	
Brown	B. P. Waldkirch		x
	F. D. Cook		x
Calumet	E. W. Humke	x	
Chippewa	M. W. Asplund	x	
Clark	M. V. Overman	x	
Columbia–Marquette–Adams	R. R. Rueckert		x
Crawford	M. S. Garrity	x	
Dane	Robert L. Beilman		x
	T. J. Nereim	x	
	R. N. Allin		x
	N. M. Clausen		x
	H. M. Suckle		x
	G. E. Oosterhous		x
	W. T. Russell		x
	R. A. Straughn		x
Dodge	L. W. Schrank		x
Door–Kewaunee	W. G. Sheets		x
Douglas	C. J. Picard	x	
Eau Claire–Dunn–Pepin	D. R. Griffith	x	
	W. R. Manz	x	
Fond du Lac	D. J. Twohig, Jr.		x
Forest	*E. F. Castaldo		
Grant	C. L. Steidinger	x	
Green	R. G. Zach		x
Green Lake–Waushara	David J. Sievers	x	
Iowa	W. D. Hamlin	x	
Jefferson	J. J. Voytek		x
Juneau			
Kenosha	Richard Powell	x	
La Crosse	G. B. Murphy, Jr.	x	
	D. L. Morris	x	
Lafayette			
Langlade			
Lincoln	R. J. Henderson	x	
Manitowoc	T. H. Rees	x	
Marathon	E. P. Ludwig		x
Marinette–Florence	J. W. Boren, Jr.		x
Milwaukee	N. G. Bauch		x
	E. L. Bernhart	x	
	D. J. Carlson	x	
	R. A. Nimz		x
	E. D. Wilkinson		x
	G. E. Collentine, Jr.	x	
	E. G. Collins	x	
	W. J. Conen	x	
	F. E. Drew	x	
	Edgar End	x	
	R. H. Lillie	x	
	G. S. Kilkenny	x	
	H. M. Klopf	x	
	H. J. Lee	x	
	George Murphy		x
	Ann Roethke	x	
	R. F. Purtell		x
	T. J. Cox		x
	D. M. Ruch		x
	A. J. Sanfelippo		x
	H. F. Twelmeyer		x
	L. R. Weinshel	x	
	S. E. Zawodny		x
Monroe			
Oconto			
Oneida–Vilas	Henry S. Ashe	x	
Outagamie	G. A. Behnke		x
	J. G. Bergwall		x
Ozaukee	J. F. Walsh		x
Pierce–St. Croix	P. H. Gutzler	x	
Polk	L. O. Simenstad	x	
Portage	F. E. Gehin	x	
Price–Taylor	J. D. Leahy	x	
Racine	V. J. Burch	x	
	William Henken	x	
Richland	D. J. Taft	x	
Rock	M. F. Purdy		x
	D. M. Clark		x
Rusk	H. F. Pagel	x	
Sauk	E. V. Stadel		x
Shawano	H. F. Laufenburg		x
Sheboygan			
Trempealeau–Jackson–Buffalo	E. P. Rohde	x	
Vernon	Robert A. Starr	x	
Walworth	E. D. Sorenson	x	
Washington	E. C. Quackenbush	x	
Waukesha	James V. Bolger, Jr.	x	
Waupaca			
Winnebago	S. J. Graiewski		x
	H. J. Colgan		x
Wood	E. C. Glenn		x
	J. W. Rupel	x	
Dermatology	Joel Taxman	x	
General Practice	J. A. Kelble	x	
Internal Medicine			
Neurology–Psychiatry			
Obstetrics–Gynecology	D. O. Price	x	
Ophthalmology–Otolaryngology			
Orthopedics	J. O. D. McCabe	x	
Pathology	J. L. Teresi	x	
Pediatrics	Richard L. Myers		x
Public Health	E. E. Bertolaet	x	
Radiology	Howard Mauthe		x
Surgery	A. G. Martin	x	
Urology	F. M. Hilpert		x

*Absent.

Doctor Carlson: I rise to state that we have four added starters. I wonder whether we can accept them at this time. I ask for your ruling on it.

Speaker Callan: They are just registering now?

Doctor Carlson: Since the roll call began.

Speaker Callan: No. The Speaker rules that it is too late. This portion of the report dealing with Resolution No. 21 has carried.

Re: Resolution No. 22

Doctor Nereim: Resolution No. 22 recommends the conducting of one-day symposiums in Madison and Milwaukee on "Town-Gown," and your Reference Committee concurs. It recommends adoption of this resolution. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: BAH Report on Blue Shield Plans

Doctor Nereim: Your Reference Committee reviewed the analysis of that portion of the Booz-Allen-Hamilton report on Blue Shield Plans, and wishes to commend the Survey Committee for its frank and comprehensive study. It takes special note that it was not the intent of the Survey Study Committee to close the door on eventual merger of the Blue Shield Plans. Your Reference Committee recommends that the findings of the Study Committee be accepted. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Supplemental Report of Survey Committee

Doctor Nereim: The supplemental report of the Survey Committee, as presented by Doctor Griffith last evening, was received. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolutions Nos. 32 and 33

Doctor Nereim: Resolutions Nos. 32 and 33, submitted by Milwaukee County, were reviewed, and your Reference Committee feels that action on these resolutions is covered by action already taken on Resolutions Nos. 1 through 22 of the Survey Study Committee. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolutions Nos. 26 through 31

Doctor Nereim: Resolutions Nos. 26 through 31, forwarded by the Council, were reviewed, and your Reference Committee reminds the House that Resolutions Nos. 26 through 29 were introduced at the October 1963 meeting.

Resolution No. 26 recommends that Chapter III, Section 1 of the Bylaws be amended by adding the sentence:

> "The House of Delegates shall hold one interim session each year."

Your Reference Committee recommends that this be adopted. I move acceptance of this portion of the report.

(Motion seconded.)

Speaker Callan: The Chair was in error when it called for a two-thirds vote on the last matter. A majority vote is necessary. Is there any discussion?

(Motion carried.)

Doctor Nereim: Resolution No. 27 recommends that Chapter VIII of the Bylaws be amended to create a new Section 6, renumbering present Sections 6 and 7, and providing for Scientific Fellows as a membership classification. Your Reference Committee agrees with this recommendation. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Doctor Nereim: Resolution No. 28 recommends that Section 1 of Chapter XI of the Bylaws be amended by the addition of the following sentence:

> "Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply."

Your Reference Committee is in agreement with this recommendation. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Doctor Nereim: Resolution No. 29 recommends that Chapter VII, Section 4 of the Bylaws be amended to increase the size of the Commission on Public Policy. Your Reference Committee concurs in this suggestion and recommends adoption of the resolution as presented. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Doctor Nereim: Resolution No. 30 recommends that Chapter VII, Section 2 of the Bylaws be amended to increase the size of the Commission on Scientific Medicine. Your Reference Committee concurs in this suggestion also, and recommends adoption of the resolution as presented. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Doctor Nereim: Resolution No. 31 deals with meetings of the Council during the Annual Session, and requires amendment of Chapter VI, Section 1 of the Bylaws. The Reference Committee is in favor of this change, and recommends adoption of the resolution as presented. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Constitutional Amendment

Doctor Nereim: Your Reference Committee reviewed the constitutional amendment relating to special sessions of the House, introduced by the Reference Committee on Resolutions in October 1963, for action at the annual meeting in May 1965, and points out that this will be brought up for definitive action at that time. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 36

Doctor Nereim: Resolution No. 36, introduced by Milwaukee County regarding civil rights, was reviewed, and your Reference Committee recommends adoption as presented. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 39

Doctor Nereim: Resolution No. 39, introduced by Wood County, also regarding civil rights, was reviewed, and your Reference Committee recommends its rejection, feeling that the subject is more adequately covered in Resolution No. 36. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Resolution No. 37

Doctor Nereim: Your Reference Committee reviewed Resolution No. 37, introduced by Milwaukee County, on the subject of the group disability plan for physicians, and feels that since further study is indicated, it wishes to refer the matter to the Council for report at a later date. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Location of 1965 and 1966 Annual Meetings

Doctor Nereim: It was the privilege of this Reference Committee to consider the matter of the location of the 1965 and 1966 annual meetings. It recommends that the 1965 meeting be held in Milwaukee and that the invitation from the La Crosse County Medical Society, as expressed in Resolution No. 40, to hold the 1966 annual meeting in the city of La Crosse, be accepted. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Commission on Medical Care Plans

Doctor Nereim: Your Reference Committee reviewed the report of the Commission on Medical Care Plans and its supplementary report as presented in the (Council) report by Doctor Fox last evening.

It was felt that the portion of the supplemental report dealing with the relationship of county societies to welfare departments was deserving of additional study, because there was a question as to whether it was a local or general problem, and that, further, the problem seemed to involve other than the problem of financial remuneration. Therefore, your Reference Committee wishes to refer that portion of the report back to the Council for further study and subsequent report.

As to the remaining portions of the supplemental report and the entire "initial" report of the Commission on Medical Care Plans (Report No. 2), your Reference Committee recommends their acceptance. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Re: Dues

Doctor Nereim: Your Reference Committee discussed the matter of dues, and recommends that this subject be considered at the October meeting of the House of Delegates, at which time the proposed budget for the next year will be available. I move acceptance of this portion of the report.

(Motion seconded and carried.)

Doctor Nereim: I now move adoption of this report as a whole.

(Motion seconded and carried.)

■ REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. James V. Bolger (Milwaukee): Your Reference Committee on Reports of Officers presents the following report:

Re: Commission on State Departments

Your Reference Committee has reviewed the report of the Commission on State Departments. Much of this report deals with the specific recommendations made by each of the Divisions; but in addition to this, the Commission recommended that a program for measles immunization be conducted through an active State-wide program by private physicians, to greatly reduce the need of gamma globulin.

Re: Division on Safe Transportation

The Commission also recommends adopting the principles for transporting the ill and injured, prepared by the Division on Safe Transportation, with the requirements relating to visual and hearing standards as qualified by the Division on Hearing and Visual Defects.

The Commission further recommends that the chairman of a division or his designee attend the Council meeting subsequent to one at which a question is raised opposing that division's recommendation, and that the Council defer action until the division chairman has an opportunity to be heard.

Your Reference Committee notes that the Commission has adopted a recommendation by the Division on Nervous and Mental Diseases supporting the Interstate Mental Health Compact, but action on this recommendation has not been taken by the Council. We recommend that this subject be returned to the Commission for further study.

Re: Division on Aging

The Reference Committee has reviewed the report of the Division on Aging. The Division report calls attention to the concentrated activity in the area of upgrading the quality of nursing homes. This is illustrated by the recently adopted Nursing Home regulations by the State Board of Health and the standards adopted by the National Council for the Accreditation of Nursing Homes.

Another recommendation by the Commission on Aging related to the development of ancillary health services on a community level where needed.

Your Reference Committee recommends that the report be adopted. I so move.

(Motion seconded and carried.)

Re: Division on Handicapped Children

Doctor Bolger: The report of the Division on Handicapped Children was reviewed, and your Reference Committee recommends that it be adopted. I so move.

(Motion seconded and carried.)

Re: Division on Maternal and Child Welfare

Doctor Bolger: The Reference Committee has reviewed the report of the Division on Maternal and Child Welfare. This Division has participated in a variety of projects now in various stages of completion. The obstetrical nurse training program proved highly successful, and its continuation is encouraged.

In order to meet the emergency needs for fibrinogen, a list of sources of supply has been sent to all hospitals. A variety of educational programs has been initiated to assist the practicing physician to improve his obstetrical knowledge and skills. The Division has assisted in developing procedures and reporting forms to facilitate adoption procedures. Pending projects are the problem of utilization of empty obstetrical beds in hospitals now filled to capacity. It is attempting to determine how these beds might be made available for general purposes, thus better utilizing hospital beds to the fullest efficiency.

The Division also recommends to the Council that the Council initiate a study of problems arising in areas of duties delegated to nurses, with and without supervision by the physician, to determine if expanded nursing care is advisable for the best patient care. It is hoped that if such a study is made, the Division on Maternal and Child Welfare may participate in such a study.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS. Left to right: Dr. M. V. Overman, Neillsville; Dr. J. V. Balger, Jr., Waukesha, chairman; Dr. F. M. Hilpert, Racine; and Dr. C. J. Strang, Barron. Not pictured: Dr. H. F. Twelmeyer, Wauwatosa.

Your Reference Committee recommends that this report be adopted. I so move.

(Motion seconded and carried.)

Re: Division on Nervous and Mental Diseases

Doctor Bolger: The Reference Committee has reviewed the report of the Division on Nervous and Mental Diseases, and your Reference Committee feels that its report of October 18, 1963 at the interim meeting, be re-emphasized—that the State Medical Society make every effort to gain physician membership on any State committees representing mental health, and it should likewise encourage physician participation in cooperating with local problems and in developing community activity in the promotion of voluntary services for the mentally ill.

Of concern to the Division was the encroachment in the area of mental health by the nonphysician.

Your Reference Committee notes that the Division is progressing with its program of postgraduate education for the non-psychiatrist physician. Your Reference Committee also reports that Bill S. 170, approved by the Division, has been enacted into law.

The Division on Nervous and Mental Diseases recommends that legislation be reintroduced to permit payment of medical care to public assistance recipients who are in a hospital primarily because of a diagnosis of psychosis. Your Reference Committee refers you to Resolution No. 41 dealing with this same subject.

The Reference Committee should point out that the Division has carried out the mandate of the House of Delegates of last year in studying the purpose and objectives of the community mental health clinics. The Division is of the opinion that these clinics could be of greater value if they would broaden their range of care and involve the local psychiatrist and physician in that community.

Your Reference Committee notes that the Division continues its efforts to find a satisfactory solution to certification of psychologists.

Your Reference Committee recommends that this report be adopted. I so move.

(Motion seconded and carried.)

Re: Division on Rehabilitation

Doctor Bolger: The report of the Division on Rehabilitation has been reviewed, and the Reference Committee notes the extensive programs conducted through the State Board of Vocational and Adult Education in certifying disability under the Social Security program and the wide use of consultative services.

The Division would like to encourage county medical societies, who have questions concerning the program, to call upon the State Board of Vocational and Adult Education for advice, and it is their hope that county medical societies will seek more information about the operation of the Rehabilitation Division. The Division has recommended that the fee schedule be revised, and has brought this to the attention of the appropriate committee of the Society.

Your Reference Committee recommends that this report be adopted. I so move.

(Motion seconded and carried.)

Re: Division on School Health

Doctor Bolger: Also reviewed was the report of the Division on School Health. The Division has revised and amplified a health examination form for use in all the schools of the State, and your Reference Committee feels that this Division might be encouraged to recommend a similar standard form for college health examinations.

The Division also recommends that the Society's publication, SCHOOL HEALTH EXAMINATIONS, not be reprinted, and that the State Board of Health and State Department of Public Instruction, with representatives of the medical and dental professions, publish a booklet for educators, and that the Society publish such information for physicians in the WISCONSIN MEDICAL JOURNAL.

The Division also recommends that the problem of increasing demands on student health services, due to rapidly increasing college enrollments, be placed before the Board of Regents of State colleges and the appropriate bodies of private colleges in the State, with an offer of Society assistance in establishing standards for college health services in Wisconsin.

The Division also feels that continued and increased physician support is needed for the physical education programs in our schools, and the Division recommends that oxygen be used only for medical purposes, under the direction of the team physician when used by athletes during athletic competition.

Your Reference Committee recommends adoption of this report. I so move.

(Motion seconded and carried.)

Doctor Bolger: It has been brought to the attention of the Reference Committee that Dr. L. M. Simonson, Sheboygan, is retiring as Chairman of the Division on School Health. This Reference Committee, on behalf of the State Medical Society, wishes to commend him for his time and effort in the development of a better school health program for the citizens of the State of Wisconsin. I move approval of this portion of the report.

(Motion seconded and carried.)

Re: Division on Visual and Hearing Defects

Doctor Bolger: The Reference Committee has reviewed the report of the Division on Visual and Hearing Defects. This Division has considered the matter of additional eye banks outside Milwaukee County, and recommends that such expansion be done with due deliberation and that no further eye bank facilities be set up in Wisconsin until the Milwaukee Eye Bank is functioning at full capacity.

The Division reviewed legislative proposals affecting visual health in the State of Wisconsin and the efforts of the Ophthalmological Legislative Committee and the State Medical Society to defeat bills 133-A and 134-A.

This Division has recommended that the Industrial Commission adopt the American Medical Association guide for determining loss of visual efficiency, and this is being considered by the Industrial Commission.

The Division wishes to remind all physicians and the State Board of Health that a guide to develop the school vision screening program has been developed, and local boards of health and public health

nurses should be kept cognizant of this publication and the principles contained in it.

Your Reference Committee recommends that this report be adopted. I so move.

(Motion seconded and carried.)

Doctor Bolger: This concludes the reports of the Divisions of the Commission on State Departments. Your Reference Committee recommends that the entire Commission report be adopted. I so move.

(Motion seconded and carried.)

Re: Menominee County Study Committee

Doctor Bolger: Your Reference Committee has reviewed Report No. 8 concerning the Menominee County Study Committee of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. We wish to commend the Committee on the establishment of this project and its efforts in seeking a solution to the present and future health care problems of this County.

Your Reference Committee recommends that this report be adopted. I so move.

(Motion seconded and carried.)

Re: Resolution No. 25

Doctor Bolger: Resolution No. 25, introduced by the Waupaca County Medical Society, was reviewed, and it was the opinion of this Reference Commitee that this resolution be sent to the Division on Chest Diseases for study and report back to the House. Your Reference Committee calls attention to the need for county medical society approval and the continuing education of the public as to the function of a screening program. I so move.

(Motion seconded and carried.)

Re. Resolution No. 35

Doctor Bolger: Your Reference Committee has considered Resolution No. 35, introduced by the Medical Society of Milwaukee County, and it approves this resolution—that the House of Delegates of the State Medical Society officially acclaim and honor Dr. W. J. Egan for his inestimable service to medicine and his community.

The Reference Committee recommends that it be adopted. I so move.

(Motion seconded and carried.)

Re: Necrology and Membership Reports

Doctor Bolger: The Necrology and Membership reports were reviewed and approved, with the request that next year the membership rolls include a breakdown of the number of licensed physicians who are not members of the State Medical Society.

Your Reference Committee recommends that these reports be adopted. I so move.

(Motion seconded and carried.)

Re: Treasurer's Report

Doctor Bolger: Your Reference Committee has reviewed the Treasurer's report as presented by Doctor Weston, and the audit as presented by Mr. John B. White, of Donald E. Gill and Company. The Reference Committee recommends the adoption of these reports. I so move.

(Motion seconded and carried.)

Re: Council Report

Doctor Bolger: Your Reference Committee has reviewed the report of the Council with the exception of Resolutions Nos. 40 and 42 and the Supplemental Report of the Commission on Medical Care Plans. Your Reference Committee follows the Council in endorsing the formation of a Section on Anesthesiology.

It was called to the attention of the Reference Committee that in the Planning Committee of the Council's study of the resolution on Alcoholism it would be appropriate to invite the Chairman of the Division on Nervous and Mental Diseases to meet with the Planning Committee when this subject is taken up.

The Reference Committee, recognizing the value of having a knowledge of Council activities, would urge the Council to extend an invitation to the members of the reference committees to attend the Council meeting just preceding the first session of the House of Delegates.

The Reference Committee recommends that this portion of the Council report be adopted. I so move.

(Motion seconded and carried.)

Re: Resolution No. 41

Doctor Bolger: The Reference Committee on Reports of Officers considered Resolution No. 41 and recommends its adoption. I so move.

(Motion seconded and carried.)

Doctor Bolger: I now move for the adoption of the report of the Reference Committee on Reports of Officers as a whole.

(Motion seconded and carried.)

■ STATEMENT BY THE SECRETARY

Secretary Crownhart: A matter which has demanded a great deal of time by both the staff and physicians has been that of HAPA implementation in Wisconsin. While the State Medical Society through its Division, Wisconsin Physicians Service, entered a bid to administer the program, it was not successful in securing that contract; but that was never our prime interest.

I think the prime interest of the State Medical Society of Wisconsin, the one which has had to be uppermost in the minds of physicians and the staff alike, has been to provide the cooperation to the State of Wisconsin in seeing that a very adequate program is developed.

This afternoon you were privileged to hear a fine and detailed presentation of current plans to implement HAPA; and along with the thanks given by the Speaker I should like to add mine, and through me the staff's thanks, for the kind of cooperation we have had from Mr. Schmidt, Tom Lucas and Doctor Allin, as well as the conferences we have enjoyed with Continental.

However, after the meeting concluded I took it upon myself to become a reference committee for a moment, and some conferences were engaged in. Mr. Schmidt, who had an evening appointment in Green Bay, changed his plans and remained available and met with me, Mr. Tiffany, our actuary, Mr. Murphy, Mr. Kluwin and others.

I feel that the matter of fee studies was perhaps not fully understood—if understood by you, then perhaps not by the Secretary; but in any event either my office or both of us needed to have the subject clarified a bit.

The development of the schedule of benefits in Wisconsin is the responsibility of the State Department of Public Welfare. It is not a responsibility of county departments. County departments are essentially autonomous and are concerned with the administration of welfare laws. What has been delegated by the State of Wisconsin to county departments is primarily in the matter of certifying beneficiaries as eligible.

Mr. Schmidt presented to you his belief that the concept of a usual, customary and reasonable fee

could be applied within the benefit provisions of HAPA. This concept is not new to Wisconsin physicians, who pioneered in its development through the special service contract. However, Mr. Schmidt also pointed out (and I believe he stated) that it was under some imposition of federal regulation, that he will need a guide to assist in federal and State auditing of benefits.

In further conversation with Mr. Schmidt and with the others of the staff, we feel that the guide will appropriately use the mechanism of a special service contract in Wisconsin, perhaps adjusted somewhat to allow consideration of the income factor involved.

Consequently, acting with the advice of the appropriate committees within the State Medical Society, the staff, with your approval of this report, will undertake forthwith to negotiate with the State Department of Public Welfare, and in the future renegotiate with them, on the over-all subject of fee considerations, recognizing, as I am sure you do, that the concept of special service is not a static thing but takes into account economic adjustments and your new scientific procedures as you develop them from time to time.

It may be quite possible (and Mr. Tiffany, our consulting actuary, believes it is possible) to develop a median schedule which will even more adequately serve the concept of special service.

I may have given impressions in caucus meetings, and even this afternoon in my questioning of these people, that I was concerned with the schedule of benefits. As a nonmedic I will derive no particular benefit from any schedule of benefits, I hope, but I do feel it is most important that the county medical societies, the medical communities of this State, which can't be considered within the confines necessarily of a county or even in some areas necessarily of a state, when you think of areas like Marinette, Menominee, Superior-Duluth, and so on—I do think it is tremendously important that you understand, that the State understands, and that the Continental understands that you are not going to be pegged to some arbitrary schedule of benefits unrealistic of your ability to achieve, as you have done for WPS, unrealistic in that ability to provide our programming in Wisconsin with a fee that is considered customary and usual in the medical community where the service is performed.

There are provisions that, should there be some situation in which complicating factors are presented, those factors may be taken into consideration.

The State Medical Society (and it will be largely through the office, by necessity) will actively participate with Mr. Schmidt, Mr. Lucas, Mr. Zepeda, who is in charge of the Wisconsin program, and any others who effectuate what I believe you would wish accomplished. I have no fiscal note attached to this particular effort, and I don't propose any.

I would like confirmation of this expression of purpose of the staff, and will be glad to try to answer any questions if the House has any.

Doctor Waldkirch: In the event such a median fee schedule as the Secretary has suggested is drawn up, will this House have a further opportunity to approve or disapprove it, or is the authorization that the Secretary is requesting final?

Mr. Carl A. Tiffany: I took part in most of the discussion regarding this meeting of a fee schedule. I do think there has to be some facility for going ahead to implement the Kerr-Mills program, but I think there is no thought on the part of the staff nor myself, and I could not detect any such feeling in anything that was said by Mr. Schmidt.

I think all administrative fee schedules under special service and under this Medicare program as we contemplate it are, as Mr. Crownhart has said, not

EXTRAORDINARY SESSION of the House of Delegates was held Monday afternoon, May 11, on the implementation of the Health Assistance Payments Act (Kerr–Mills) with representatives of the State Department of Public Welfare and Continental Insurance Company explaining proposed operation of the program in Wisconsin. Transcript of the session will be published in the October issue. Elmer Rassmusen, vice-president of Continental, is pictured above left; Wilbur Schmidt, director of the State Department of Public Welfare, above right.

a static thing but a living thing that will have to move from time to time and rather follow the practice of medicine and the charges for the practice of medicine as they occur. For administration as at any moment of time there will have to be a fixed figure for clerical evaluation of whether or not this particular fee needs additional information or not. I hope that clarifies the question.

President Egan: I would like to have the delegate's question answered. The delegate's question was definite, and I would like to have it answered.

Speaker Callan: President Egan requests that the delegate's question be answered more specifically, Mr. Tiffany.

Mr. Tiffany: I think whether or not it comes back to the House is for the House to say. In the absence of that, I do think the administrative people have to start out with a fee schedule and change it when conditions change or when they are told to change it. I don't know how to answer the question any more precisely, Doctor.

Dr. W. R. Manz (Eau Claire): One of the questions asked this afternoon was whether outpatient diagnostic services would be covered. The answer was made that yes, they would be covered under the customary hospital charges. I would like to point out at this time that these represent professional services and should be paid for as such. I strongly urge that in the implementation of this program this be pointed out and carried out if possible.

Doctor Waldkirch: I am confused as to what the matter is that is before the House. What are we being asked to approve or disapprove?

Speaker Callan: We are really not being asked to approve or disapprove anything. It was an expression, as I understood it, by our Secretary on the HAPA situation as he now sees it. Is that true, Mr. Crownhart?

Secretary Crownhart: That is correct. It had not occurred to me until this afternoon that the negotiations were going to have to be conducted so fully at the State level, and I had anticipated erroneously that much of the negotiations would be more with each of the medical communities. However, none of that responsibility in the area of surgical-medical benefits is being assigned to the counties, and therefore the State Department will be involved. Q.E.D., I think the State Medical Society through WPS and

the information that it has achieved over the years with special service contracts should likewise be involved, and we should use the best of our abilities to keep any static schedule from developing, and having one that moves ahead in the light of economic and other needs.

Doctor Waldkirch: I gather from the Secretary's first remarks that he hoped to devise or produce or gather some kind of median fee schedule. Perhaps I was wrong in that inference. He used the word "median."

Secretary Crownhart: Yes, I did. Mr. Tiffany, I wish you would come up here in case I get into trouble.

A median fee schedule, as it was explained to me, is not a pegged schedule but anticipates costs in some areas less than the peak, and costs in others perhaps over the peak. It comes back into an average or another term or median as a control point. If the sum total of all payments can be related to the peak, then we develop the ability to meet the customary and reasonable charges without pegging some negotiated schedule.

Speaker Callan: This is a situation that I think perhaps calls for more discussion at the committee level rather than before the House of Delegates.

Dr. F. E. Drew (Milwaukee): I would like to request a ten-minute recess so that I may discuss this with the Milwaukee delegation. I would like to make that in the form of a motion.

(Motion lost.)

Dr. E. M. Dessloch (Prairie du Chien): I think you are disturbed about a term, and that is "median." That actually is only an actuarial term and has nothing to do with the fee schedule as such. If you consider that, you have the end result of the usual customary and reasonable fee in your community. I think that solves the whole problem.

Speaker Callan: The Speaker thinks the House is confused as to just what order of business this is, and I must admit I am a little confused, too. An officer of course has the right to bring new business before the House, according to the Constitution and Bylaws.

Is there any other expression as to what the House's desires are at this point?

Doctor Bergwall: If we clarify the situation by making this suggestion, may I suggest that our State Secretary exercise his negotiations in the full sense of the term, "usual and customary fees," on the local and county basis. That ought to eliminate a lot of questions on the part of individual counties as to whether or not there will be a median for the entire State.

Speaker Callan: Do you make a motion to that effect, Doctor? We need unanimous consent of the House for a motion to that effect.

Secretary Crownhart: Unless there is some contrary instruction, what the Secretary is going to try to do is to get you your reasonable and customary fees as you now make those charges in each medical community. That is the effort that will be made.

Speaker Callan: Is it clear to the House that the Secretary will try to achieve the usual customary and reasonable fees?

Doctor Waldkirch: The reason I am concerned about this is that many of our members are unhappy with certain features of the insurance program. If the Secretary is instructed or permitted to carry on these negotiations himself, without representation or supervision or participation by physicians of the Society, there will be excuse for criticism of the results. Therefore, although I am aware no one in the Society is better able to carry on such negotiations, I think there should be a committee or some other arrangement made so that the membership at large knows that this is not a one-man operation.

Speaker Callan: The Chair will proceed with the next order of business.

For clarification, the roll call vote was clearly for the removal of the restrictions. There were 53 for the motion and 39 against, in case any of you want the results of that roll call vote.

Is there any further business?

Secretary Crownhart: There are three items. I make my annual plea, more fervently than usual, that you do patronize the exhibitors. A fiscal note: $26,000 of income finances the annual meeting in toto. The attendance as reported to me today is quite low, and a return to a Tuesday-Wednesday-Thursday program will probably help, but please give us a boost tomorrow.

Somewhere along the line the recommendation of the Council for October 9–10 as the meeting date for the fall session didn't get into the reports. We assume this is approved.

Tomorrow night we need a grand turnout. Doctor Blasingame will be here. You will hear from one of the finest leaders of American medicine with whom I am acquainted. We will hear Doctor Egan's farewell, and Doctor Curran's debut. So, I do hope you show up.

Dr. R. N. Allin: I move we adjourn.

(Motion seconded and carried.)

TUESDAY MORNING SESSION

May 12, 1964

REPORT OF CREDENTIALS COMMITTEE

Doctor Carlson: The Committee on Credentials has verified the registration of 67 delegates and 9 alternate delegates, representing 43 county medical societies and 3 sections entitled to vote at this session of the House of Delegates.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 76, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

■ REPORT OF THE COMMITTEE ON NOMINATIONS—MAY, 1964

Speaker Callan: Your Speaker reminds you that nominations by the Committee do not preclude additional nominations being made from the floor. We will act upon each nomination separately so as to permit additional nominations from the floor, if there be any.

I now call upon the Chairman of the Committee on Nominations to make his report, which under the Bylaws must be in the form of a ticket containing the name of the nominee or nominees for each of the offices to be filled at this session.

Dr. H. M. Suckle (Madison): The Nominating Committee, composed of one delegate from each Councilor district, has the pleasure and honor to present the following nominees for official positions in the State Medical Society of Wisconsin:

For the office of President-elect, Dr. John Houghton of Wisconsin Dells.

For the office of Vice Speaker, Dr. Theodore Nereim, of Madison.

PAST PRESIDENTS. Luncheon gathering Wednesday, May 13. Seated left to right: Drs. J. C. Griffith, Milwaukee; W. P. Curran, Antigo; W. J. Egan, Milwaukee; N. A. Hill, Madison; H. E. Kasten, Beloit; A. J. McCarey, Green Bay; and H. K. Tenney, Madison. Standing left to right: Drs. E. L. Bernhart, Milwaukee; Gunnar Gundersen, La Crosse; R. P. Sproule, Milwaukee; M. A. McGarty, La Crosse; K. H. Doege, Marshfield; W. B. Hildebrand, Menasha; W. D. Stovall, Madison; L. H. Lakvam, Kenosha; E. D. Sorenson, Elkhorn; and L. O. Simenstad, Osceola.

For the office of Delegate to the American Medical Association to succeed Dr. John Bell, of Marinette, Doctor Bell to succeed himself.

To succeed Dr. E. L. Bernhart, of Milwaukee, Doctor Bernhart.

For the office of Alternate Delegate to the American Medical Association to succeed Dr. James Fox, Doctor Fox to succeed himself.

To succeed Dr. Charles Picard as Alternate Delegate to the American Medical Association, Doctor Picard to succeed himself.

ELECTION OF OFFICERS

Speaker Callan: The first nomination is that of Dr. John Houghton of Wisconsin Dells for the office of President-elect. Other nominations are in order at this time. Are there any other nominations for the office of President-elect? Hearing none, a motion is in order to close nominations and direct the Secretary to cast the unanimous ballot of the House for the nominee. Do I hear such a motion?

Dr. V. J. Burch (Racine): I so move.

(Motion seconded and carried.)

Speaker Callan: The next nomination is that of Dr. Theodore Nereim, of Madison, as Vice-speaker of the House. Are there any other nominations?

Dr. F. D. Cook (Green Bay): I would like to place in nomination the name of Dr. George Behnke, from Outagamie County, as Vice-speaker of the House of Delegates.

Speaker Callan: The name of Dr. George Behnke of Outagamie County has been placed in nomination. Are there any other nominations? If not, we will have a written ballot and the result will be made known to you by the Chair.

For your further information, at the 1949 session the House approved a motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association will be utilized, wherein the roll call of registered delegates is called from the Speaker's rostrum, and as his name is called the delegate or alternate delegate entitled to vote will come up and deposit his ballot so that there can be an accurate count against the registration.

Is everyone registered? We will now have a supplemental report of the Credentials Committee.

SUPPLEMENTAL REPORT OF CREDENTIALS COMMITTEE

Doctor Carlson: In addition to those delegates already registered and reported by the Committee on Credentials, 7 delegates have registered and are entitled to vote.

I move that this attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 83, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

(Balloting.)

Speaker Callan: The Chair wishes to appoint as tellers Dr. James Bolger, Jr. and Doctor Gehin.

ELECTION OF DELEGATES

Speaker Callan: While the counting is going on we will proceed to the next order of business, the election of delegates to the American Medical Association. The Nominating Committee has submitted the name of Dr. John Bell to succeed himself. Are there any other nominations? If not, the Chair will entertain a motion that nominations be closed and that the Secretary be directed to cast the unanimous ballot for Doctor Bell as AMA delegate.

Dr. E. D. Sorenson (Elkhorn): I so move.

(Motion seconded and carried.)

Speaker Callan: The next nomination is that of Dr. E. L. Bernhart to succeed himself as AMA delegate. Are there any other nominations? Hearing none, a motion is in order to close nominations and instruct the Secretary to cast the unanimous ballot for Dr. Bernhart.

Doctor Burch: I so move.

(Motion seconded and carried.)

OFFICERS. Left to right: Dr. W. P. Curran, Antigo, newly elected president; Dr. J. H. Haughton, Wisconsin Dells, president-elect; and Dr. W. J. Egan, Milwaukee, past president.

Speaker Callan: Next is the nomination of alternate delegates to the AMA. To succeed Dr. James Fox, the Nominating Committee has presented the name of Dr. James Fox to succeed himself. Are there any other nominations? Hearing none, a motion is in order to close nominations and instruct the Secretary to cast the unanimous ballot. Do I hear such a motion?

Doctor Allin: I so move.

(Motion seconded and carried.)

Speaker Callan: The next nominee is Dr. Charles Picard to succeed himself as alternate delegate to the AMA. Are there any other nominations? Hearing none, a motion is in order to close nominations and instruct the Secretary to cast the unanimous ballot for Doctor Picard for alternate delegate to the AMA.

Doctor Burch: I so move.

(Motion seconded and carried.)

Speaker Callan: At this time the Chair would like to appoint a committee to escort the President-elect to the rostrum. The committee will consist of Dr. Charles Picard, Doctor Suckle as Chairman of the Nominating Committee, Doctor Egan as our retiring President, and Doctor Curran, our incoming President.

We will now proceed to the election of Councilors.

ELECTION OF COUNCILORS

Speaker Callan: In the Third District, to succeed Dr. E. J. Nordby, of Madison. Will the Third District report its nominee.

Doctor Suckle: The Third District would like to nominate Dr. E. J. Nordby to succeed himself as Councilor from our District.

Speaker Callan: Nominations for Councilor must arise from the Councilor district itself. Are there any other nominations? The election is by the House of Delegates.

(Reelected.)

In the Fourth District, to succeed Dr. E. M. Dessloch of Prairie du Chien.

Dr. W. D. Hamlin (Mineral Point): The Fourth District nominates Dr. E. M. Dessloch to succeed himself.

(Reelected.)

Speaker Callan: In the Fifth District, to succeed Dr. P. B. Blanchard, of Cedarburg. Will the Fifth District please report their nominee.

Dr. J. W. McRoberts (Sheboygan): The Fifth District nominates Doctor Blanchard to succeed himself.

(Reelected.)

In the Sixth District, to succeed Dr. H. J. Kief, of Fond du Lac.

Dr. David J. Twohig (Fond du Lac): We nominate Doctor Kief to succeed himself.

(Reelected.)

Speaker Callan: In the Twelfth District, to succeed Dr. D. M. Willson, of Milwaukee.

Doctor Drew: The Twelfth District would like to nominate Dr. Howard Lee to succeed Doctor Willson.

(Elected.)

Speaker Callan: The new Vice-speaker to succeed Doctor Carey is Dr. George Behnke, with a vote of 44 to 39.

At this time the Chair would like to ask the committee to escort our new President-elect to the rostrum.

While we are awaiting the presence of Doctor Houghton, on behalf of the Society I would like to take this opportunity to thank Doctor Willson, past Councilor from the Twelfth District, for the very valuable work he has contributed to the Society in the past many years. We shall miss him.

Also, I would like to thank the fine gentleman to my right, the Vice-speaker, Doctor Carey, who certainly has been my strong right arm in the past three years.

Is Doctor Gundersen in the House? I don't see him, but I thought it would be appropriate to at least introduce our eminent Past President of the American Medical Association at this meeting of the House.

The Speaker would also like to thank Doctor Allin for taking the trouble to make preparations for the excellent educational film for our members, which we all appreciated.

I would also like to thank the reference committee chairmen, Doctor Nereim, Doctor Bolger and Doctor Gehin, for their very excellent work, and the reference committee members for their equally excellent work and effort.

The Speaker appreciates, as I am sure the Society does, the fine performance of the House of Delegates. I think it will fulfill the initial views of the Speaker that the House is truly a legislative body and its processes are democratic. The Speaker is quite proud that the House has fulfilled that goal.

The Speaker would also like to thank the staff of the State Medical Society, especially Mr. Charles Crownhart, for his customary tremendous effort. Mr. Roy Ragatz, for his scientific and other efforts to make this meeting a success. Mr. Ed Mulady, who was largely responsible for the communication on Kerr-Mills arrangements the other day. Joan Pyre and Jean Anderson, our stalwarts, who keep everything going right and who made the reference committee reports possible, and all the other members of the staff too numerous to mention.

PRESENTATION OF NEW PRESIDENT-ELECT

Dr. John Houghton (Wisconsin Dells): It is with great humility that I accept this honor you have given me. In return, I promise to serve to the best of my ability, and I hope in the tradition of all the fine men who have preceded me.

Speaker Callan: A motion to adjourn sine die is in order.

Doctor Burch: I so move.

(Motion seconded and carried.)

(House adjourned sine die.)

■ ATTENDANCE AT HOUSE OF DELEGATES

SOCIETY:	Sessions 1	X	2	3
Ashland-Bayfield-Iron				
C. A. Grand, Ashland	x	x	x	x
J. M. Jauquet, Ashland	o	o	o	o
Barron-Washburn-Sawyer-Burnett				
C. J. Strang, Barron	x	x	x	x
Robert Anderson, Cumberland	o	o	o	o
Brown				
B. P. Waldkirch, De Pere	x	x	x	x
Donel Sullivan, Green Bay	x	x	o	x
F. D. Cook, Green Bay	x	x	x	x
M. D. Blackburn, Jr., Green Bay	o	o	x	o
Calumet				
E. W. Humke, Chilton	o	o	x	x
A. C. Engel, New Holstein	o	x	x	o
Chippewa				
M. W. Asplund, Bloomer	x	x	x	x
J. J. Sazama, Chippewa Falls	o	o	o	o
Clark				
M. V. Overman, Neillsville	x	x	x	x
R. L. Hansen, Colby	o	o	o	o
Columbia-Marquette-Adams				
R. R. Reukert, Portage	x	x	x	x
R. T. Cooney, Portage	x	x	x	x
Crawford				
M. S. Garrity, Prairie du Chien	x	x	x	x
T. F. Farrell, Prairie du Chien	o	o	o	o
Dane				
Robert L. Beilman, Madison	o	o	x	x
F. D. Bernard, Madison	x	o	o	o
T. J. Nereim, Madison	x	x	x	x
K. L. Siebecker, Madison	x	x	x	x
R. N. Allin, Madison	x	x	x	o
A. J. Richtsmeier, Madison	x	x	x	o
N. M. Clausen, Madison	x	x	x	x
R. P. Sinaiko, Madison	o	o	o	o
H. M. Suckle, Madison	x	x	x	x
P. G. Piper, Madison	o	o	o	o
A. P. Schoenenberger, Madison	o	o	o	o
G. E. Oosterhous, Madison	x	o	x	x
W. T. Russell, Sun Prairie	x	x	x	x
C. K. Kincaid, Madison	x	o	x	o
R. A. Straughn, Madison	x	x	x	x
G. J. Derus, Madison	x	x	x	x
Dodge				
L. W. Schrank, Waupun	x	x	x	x
R. E. Urbanek, Beaver Dam	x	x	x	x
Door-Kewaunee				
W. G. Sheets, Sturgeon Bay	x	x	x	x
Patricia Lanier, Kewaunee	o	o	o	o
Douglas				
C. J. Picard, Superior	x	x	x	x
R. P. Fruehauf, Superior	x	x	x	x
Eau Claire-Dunn-Pepin				
D. R. Griffith, Eau Claire	x	x	x	x
G. G. Giffen, Eau Claire	o	o	o	o
A. A. Drescher, Menomonie	o	o	o	o
W. R. Manz, Eau Claire	x	x	x	x
Fond du Lac				
D. J. Twohig, Jr., Fond du Lac	x	x	x	x
W. E. Myers, Fond du Lac	o	o	x	o
Forest				
E. F. Castaldo, Laona	x	o	x	x
B. S. Rathert, Crandon	o	o	o	o
Grant				
C. L. Steidinger, Platteville	x	x	x	x
H. W. Carey, Lancaster	x	x	x	x
Green				
R. G. Zach, Monroe	x	x	x	x
W. J. Staab, Jr., Monroe	x	x	x	x
Green Lake-Waushara				
David J. Sievers, Berlin	o	x	x	x
Russell Darby, Wautoma	o	o	o	o
Iowa				
W. D. Hamlin, Mineral Point	x	x	x	x
S. B. Marshall, Hollendale	o	o	o	o
Jefferson				
J. J. Voytek, Fort Atkinson	o	o	x	x
R. R. Liebenow, Lake Mills	o	o	o	o
Juneau				
M. S. Tverberg, Mauston	o	o	o	o
Jack Strong, Mauston	o	o	o	o
Kenosha				
Richard Powell, Kenosha	x	x	x	x
Walter Rattan, Kenosha	o	x	o	o
La Crosse				
G. B. Murphy, Jr., La Crosse	x	o	x	x
Mark O'Meara, La Crosse	o	o	o	o
D. L. Morris, West Salem	x	x	x	o
Frederick H. Wolf, La Crosse	o	o	o	x
Lafayette				
N. A. McGreane, Darlington	o	o	x	x
Lyle L. Olson, Darlington	o	o	o	o
Langlade				
Dee W. Dailey, Elcho	o	o	o	o
John E. McKenna, Antigo	o	o	o	o
Lincoln				
R. J. Henderson, Tomahawk	x	x	x	x
J. F. Bigalow, Merrill	x	x	x	x
Manitowoc				
T. H. Rees, Manitowoc	x	x	x	x
W. F. Smejkal, Manitowoc	o	o	x	x
Marathon				
E. P. Ludwig, Wausau	x	x	x	o
A. H. Stahmer, Wausau	o	o	x	x
Marinette-Florence				
J. W. Boren, Jr., Marinette	x	x	x	x
C. E. Koepp, Marinette	o	o	o	o
Milwaukee				
V. L. Baker, Milwaukee	o	o	o	x
R. T. Sproule, Milwaukee	o	o	x	x
N. G. Bauch, Milwaukee	o	x	x	o
W. L. Coffey, Jr., Milwaukee	o	o	o	o
E. L. Bernhart, Milwaukee	x	x	x	x
L. E. Rothman, Milwaukee	o	o	o	o
D. J. Carlson, Milwaukee	x	x	x	x
R. B. Pittelkow, Milwaukee	x	o	x	o
J. F. Cary, Milwaukee	x	o	o	x
R. A. Nimz, Milwaukee	x	x	x	o
E. D. Wilkinson, West Allis	x	x	x	x
Rex Ruppa, Milwaukee	o	o	o	o
G. E. Collentine, Jr., Milwaukee	x	o	x	o
John Bareta, Milwaukee	o	o	o	o
E. G. Collins, West Allis	x	x	x	x
F. J. Millen, Milwaukee	o	o	o	o
W. J. Conen, Milwaukee	x	x	x	o
E. J. Schmidt, Wauwatosa	x	x	o	x
F. E. Drew, Milwaukee	x	x	x	x
P. G. LaBissoniere, Milwaukee	x	o	x	o
Edgar End, Milwaukee	x	o	x	x
G. W. Dean, Milwaukee	x	o	x	x
Norbert Enzer, Milwaukee	x	o	o	x
R. H. Lillie, Milwaukee	o	o	x	o
G. W. Hilliard, Jr., Milwaukee	x	o	x	x
T. F. Jennings, Milwaukee	o	o	o	o
G. S. Kilkenny, Milwaukee	x	o	x	x
R. J. Snartemo, Milwaukee	o	o	o	o
H. M. Klopf, Milwaukee	x	x	x	x
B. J. Peters, Milwaukee	o	o	x	o
H. J. Lee, Milwaukee	x	o	x	x
W. H. Frackelton, Milwaukee	o	o	o	o
George Murphy, South Milwaukee	x	x	x	o
R. H. Frederick, West Allis	o	o	o	o
Ann Roethke, Milwaukee	x	x	x	x
R. R. Watson, Milwaukee	o	o	x	x
R. F. Purtell, Milwaukee	x	x	x	x
Roger Laubenheimer, Milwaukee	x	o	x	o
F. A. Ross, Milwaukee	o	o	o	o
T. J. Cox, Milwaukee	x	o	x	x
D. M. Ruch, Milwaukee	x	o	x	o
K. A. Liefert, Wauwatosa	x	o	x	x
A. J. Sanfelippo, Milwaukee	o	o	x	x
J. R. O'Connell, Milwaukee	o	o	x	o
C. M. Schroeder, Milwaukee	x	o	x	x
K. E. Sauter, Milwaukee	o	o	o	o
H. F. Twelmeyer, Wauwatosa	o	o	x	o
D. W. Calvy, Milwaukee	o	o	o	o
L. R. Weinshel, Milwaukee	x	x	x	x
W. S. Polacheck, Milwaukee	o	o	o	o
S. E. Zawodny, Milwaukee	x	x	x	o
J. R. Evrard, Milwaukee	o	o	o	o

	Sessions 1	X	2	3
Monroe				
C. B. Koch, Lisbon	o	o	o	o
R. G. Konicek, Tomah	o	o	o	o
Oconto				
G. R. Sandgren, Suring	o	o	o	o
J. R. Culver, Oconto Falls	o	o	o	o
Oneida-Vilas				
Marvin Wright, Rhinelander	x	o	o	o
Henry S. Ashe, Minocqua	x	x	x	x
Outagamie				
G. A. Behnke, Kaukauna	x	x	x	x
J. H. Russell, Appleton	o	o	o	o
W. H. Hale, Appleton	o	o	o	o
J. G. Bergwall, Hortonville	x	x	x	x
Ozaukee				
J. F. Walsh, Port Washington	x	x	x	x
R. H. Dorr, Belgium	x	x	x	o
Pierce-St. Croix				
P. H. Gutzler, River Falls	o	x	x	x
O. H. Epley, New Richmond	o	o	o	o
C. A. Olson, Baldwin	x	x	x	x
Polk				
L. O. Simenstad, Osceola	x	o	x	x
R. M. Moore, Frederic	o	o	o	o
Portage				
F. E. Gehin, Stevens Point	x	x	x	x
A. J. Sowka, Stevens Point	o	x	o	x
Price-Taylor				
J. D. Leahy, Park Falls	x	x	x	x
J. L. Murphy, Park Falls	o	o	o	o
Racine				
V. J. Burch, Racine	x	o	x	x
Richard Minton, Racine	o	o	o	o
Wm. Henken, Racine	x	o	x	x
R. B. Leitschuh, Racine	o	o	o	o
Richland				
R. E. Housner, Richland Center	x	o	o	o
D. J. Taft, Richland Center	o	x	x	o
L. M. Pippin, Richland Center	o	o	o	x
Rock				
M. F. Purdy, Janesville	x	x	x	x
C. M. Carney, Beloit	o	x	o	o
D. M. Clark, Beloit	x	x	x	x
J. R. Schroder, Janesville	x	o	o	o
Rusk				
H. F. Pagel, Ladysmith	x	o	x	o
M. L. Whalen, Bruce	o	o	o	o
Sauk				
E. V. Stadel, Reedsburg	x	x	x	x
J. A. Tibbitts, Reedsburg	o	o	o	o
Shawano				
H. F. Laufenburg, Shawano	x	o	x	x
D. A. Jeffries, Shawano	o	o	o	o
Sheboygan				
J. W. McRoberts, Sheboygan	x	x	x	x
William W. Moir, Sheboygan	o	o	o	o
Trempealeau-Jackson-Buffalo				
E. P. Rohde, Galesville	x	x	x	x
W. E. Wright, Mondovi	x	x	x	x
Vernon				
Robert A. Starr, Viroqua	x	x	x	x
Thomas Boston, Hillsboro	o	o	o	o
Walworth				
E. D. Sorenson, Elkhorn	x	x	x	x
R. S. Galgano, Delavan	x	o	o	o
Washington				
E. C. Quackenbush, Hartford	x	x	x	x
W. A. Nielsen, West Bend	o	x	x	o
Waukesha				
James V. Bolger, Jr., Waukesha	x	x	x	x
C. Samuelson, Hartland	o	o	o	o
Robert Monk, Waukesha	x	x	x	x
Thomas Dugan, Waukesha	o	x	o	o
Waupaca				
Kenneth L. Haman, Waupaca	o	x	o	o
Jerry Salan, Waupaca	o	o	o	o

	Sessions 1	X	2	3
Winnebago				
E. A. Strakosch, Oshkosh	o	o	o	o
S. J. Graiewski, Oshkosh	x	x	x	o
H. J. Colgan, Neenah	x	x	x	x
John Nebel, Menasha	o	o	o	o
Wood				
E. C. Glenn, Wisconsin Rapids	x	x	x	x
W. B. Larkin, Marshfield	o	o	o	o
J. W. Rupel, Marshfield	x	o	x	x
John E. Thompson, Nekoosa	o	o	o	o
SECTION:				
Dermatology				
Joel Taxman, Milwaukee	x	o	x	x
Thomas S. Kemp, Madison	o	o	x	o
General Practice				
R. R. Richards, Eau Claire	o	o	o	o
J. A. Kelble, Milwaukee	x	x	x	o
Internal Medicine				
L. J. Kurten, Racine	o	o	o	o
R. L. Gilbert, La Crosse	o	o	o	o
Neurology-Psychiatry				
R. E. O'Connor, Madison	o	o	o	o
Edward E. Houfek, Sheboygan	o	o	o	o
Obstetrics-Gynecology				
D. O. Price, Madison	x	x	x	x
Leo Grinney, Racine	x	o	o	o
Ophthalmology-Otolaryngology				
R. T. Schmidt, Green Bay	o	x	x	x
R. T. Rank, Milwaukee	x	o	o	o
Orthopedics				
J. O. D. McCabe, Milwaukee	x	o	x	o
John Van Driest, Sheboygan	o	o	o	o
Pathology				
J. L. Teresi, Milwaukee	x	o	x	x
L. W. Kleppe, Beloit	x	x	x	x
Pediatrics				
Richard L. Myers, Green Bay	x	x	x	x
Edward Zupanc, Monroe	o	o	o	o
Public Health				
E. E. Bertolaet, Milwaukee	x	o	x	o
G. M. Shinners, Green Bay	o	o	o	o
Radiology				
Howard Mauthe, Racine	x	x	x	x
L. E. Jones, Racine	o	o	o	o
Surgery				
J. A. Killins, Green Bay	o	o	o	o
A. G. Martin, Milwaukee	o	o	x	o
Urology				
F. M. Hilpert, Racine	o	x	x	x
A. J. Jacobsen, Racine	o	o	o	o

First name is delegate, indented name is alternate. x—present. o—absent. X—extraordinary session.

MILWAUKEE MEDICAL CONFERENCE

Wednesday and Thursday, November 11–12
Milwaukee County Hospital

The Medical Society of Milwaukee County is sponsoring this fourth annual event in cooperation with other medical groups and Milwaukee area hospitals. Registration fee is $5.00. Inquiries should be addressed to: 1964 Milwaukee Medical Conference, The Medical Society of Milwaukee County, 756 N. Milwaukee St., Milwaukee, Wis. 53202. Further details can be found in the MEDICAL MEETINGS section of the August issue.

Minutes of Council Meeting

MILWAUKEE, MAY 10, 1964

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 1:25 p.m. on Sunday, May 10, 1964, at the Hotel Schroeder in Milwaukee.

Voting members present were Doctors Schulz, Nordby, Davis, Stoops, Dessloch, Blanchard, Kief, Nadeau, Fox, Bell, Mason, Frank, Willson, Chojnacki, Hollenbeck, W. J. Houghton, Van Hecke, Wright, President Egan and Speaker Callan.

Officers and others present: President-elect Curran, Treasurer Weston, Vice Speaker Carey; Doctors Bernhart, Quisling and Galasinski, AMA Delegates; Doctors Collentine, Hildebrand and Picard, Alternate Delegates; Doctor Simenstad, AMA Trustee; Doctors Bolger, Nereim and Gehin, reference committee chairmen; Messrs. Crownhart, Toser, Murphy, White, Kluwin, Ragatz, Hansen, Blaine; Mrs. Anderson, Miss Cordts, Miss Pyre; Charles Johnson, AMA field staff.

2. Approval of Minutes

On motion of Doctors Blanchard–Schulz, carried, minutes of the Annual Council meeting, March 14–15, 1964, were approved as distributed.

3. La Crosse County Resolution; Annual Meeting Schedule

Mr. Ragatz discussed his survey of facilities in La Crosse, concluding that they would accommodate an Annual Meeting of the State Medical Society in 1966 as invited in the resolution.

On motion of Doctors Blanchard–Hollenbeck, carried, the Council recommended favorable action by the House. (See House proceedings, Resolution 40 transmitted in report of Council.)

On motion of Doctors Willson–Hollenbeck, carried, the Council recommended that the scientific sessions revert to a Tuesday-Wednesday-Thursday schedule, with the first session of the House on Monday night.

4. Report of the Committee of Past Presidents—125th Anniversary Year

Doctor Curran reviewed minutes of its April 19 meeting, which were distributed to the Council, on preliminary planning for the 125th Anniversary Year of 1966.

On motion of Doctors Nordby–Dessloch, carried, the Council approved the recommendation that the Past Presidents be constituted a permanent committee of the Council.

On motion of Doctors Curran–Egan, carried, the report of the committee was accepted.

5. Election of Commission on State Departments

A motion by Doctors Willson–Mason that this election be postponed until the Council meeting following adjournment of the House of Delegates was defeated.

By several motions duly made, seconded and carried, the following were nominated and elected to the Commission on State Departments for the ensuing year:

T. W. Tormey, Jr., M.D., Madison, General Chairman
L. M. Simonson, M.D., Sheboygan, Vice Chairman

Division Chairmen:
A. M. Hutter, M.D., Fond du Lac, Aging
H. A. Anderson, M.D., Stevens Point, Chest Diseases
J. W. Nellen, M.D., Green Bay, Handicapped Children
John R. Evrard, M.D., Milwaukee, Maternal and Child Welfare
Charles Wunsch, M.D., Green Bay, Nervous and Mental Diseases
H. W. Carey, M.D., Lancaster, Public Assistance
Paul Dudenhoefer, M.D., Milwaukee, Rehabilitation
R. B. Windsor, M.D., Sheboygan, Safe Transportation
J. C. H. Russell, M.D., Fort Atkinson, School Health
Meyer S. Fox, M.D., Milwaukee, Visual and Hearing Defects

6. Ad Hoc Committee on Section Organization

Mr. Blaine distributed and summarized a preliminary report of this Council committee covering two meetings and a membership survey. The committee hoped to report specific recommendations before the 1964 interim session of the House.

On motion of Doctors Willson Nadeau, carried, the interim report was received without action.

There was then discussion of the pending application from the anesthesiologists for approval of section status. Council action was reviewed, the latest position being (May 1962) that "no more sections be admitted until the structure and organization of the State Medical Society has been studied."

On motion of Doctors Nadeau–Frank, carried, the Council recommended to the House that a Section on Anesthesiology be established under the appropriate section of the Bylaws.

7. Commission on Medical Care Plans

(a) Supplementary Report to Council and House

The Council had received with the agenda a report supplementary to that reviewed in March and transmitted to delegates. It was summarized by Doctor Dessloch and dealt with the following subjects:

Resolutions 1 and 2, October 1963 interim session, introduced by the Fond du Lac County Medical Society
Resolution on Pathology and Radiology, May 1963 session
Revision of "A" scheduled contract
Benefits for nervous and mental diseases

In discussion of that portion of the report dealing with the Fond du Lac resolutions, the opinion was expressed by several that these resolutions might more properly be studied by the Commission on State Departments, although they had been referred by the Council to the Commission on Medical Care Plans. Doctor Callan expressed agreement with the Commission's report, particularly in view of the forthcoming effective date of Kerr–Mills implementing legislation.

With reference to the resolution on pathology and radiology, Doctor Frank requested the privilege of inserting in the record the following excerpts from

a letter by a member to the president of the Wisconsin Radiological Society:

"I talked with Mr. Crownhart's office and Doctor Dessloch's report to the Council has not been formulated and will probably merely state that further discussions are taking place regarding resolution number 9. We must not be satisfied with a statement that 'further meetings are scheduled.' Our present efforts to do our own billing might well be successful. However, it would do no harm to resolve at the coming meeting in Milwaukee (1) to restate the fact that pathological and radiological services are medical and not hospital services; (2) resolution number 9 has not been implemented during the past year by the Commission on Medical Care Plans; (3) similar resolutions over a period of many years have not been implemented; (4) the Council is on record opposing the billing of medical services by third parties; (5) resolve that WPS discontinue payment to hospitals for pathological and radiological services; and (6) further resolve that payments for pathological and radiological services shall be made in the name of the physician who performs the services and who bills for these services. Such resolutions at the coming meeting would serve several purposes. They would emphasize our continued efforts and would publicize our problem. As the number of these resolutions increases, it may serve to point out our frustration with the past action of the Commission on Medical Care Plans. If the Council has a conscience, it cannot continue to support a system of payment to third parties for physicians' services and at the same time state that such a system is intolerable in its discussions concerning Medicare and socialized medicine. In addition, it will tend to support our efforts to do our own billing and should not fail to impress upon a third party that this effort is that of the entire medical profession and not the private acts of the radiologist and the pathologist."

The supplementary report was approved for transmittal to the House as presented. (See House proceedings, report of Council.)

(b) Insurance Director

Doctor Dessloch reported further that a full-time insurance director would probably soon be selected. He asked that the Council reaffirm prior authorization of the position.

On motion of Doctors Dessloch–Blanchard, carried, the Council reaffirmed the position of Insurance Director in appreciation that it will henceforth be on a full-time basis.

8. Distinguished Service Award for Research in Medical Science

On motion of Doctor Nordby, seconded and carried, the Council confirmed mail ballot approval of establishment of this award, and the following qualifications and procedures:

(a) This award is on nomination of the Commission on Scientific Medicine to the Council.
(b) Unanimous vote of the Council is required.
(c) Ballot may be by mail.
(d) Nominees need not be physicians but may include non-physicians whose contributions to the basic sciences are considered outstanding.
(e) The award shall be worded to the individual, in format that of the first such award made in 1964 to Armand J. Quick, M.D., Ph.D.
(f) More than one such award can be made in the same year.
(g) The award shall be presented at the time of the Annual Dinner.
(h) The purpose of the award shall be included in the remarks made by the individual selected to make the presentation and shall include the following:

"The Commission on Scientific Medicine and the Council of the State Medical Society of Wisconsin have created the Distinguished Service Award for Research in Medical Science appropriately to acknowledge, as the occasion indicates, outstanding contributions to the science and art of medicine by individuals engaged in the teaching of or research in the basic sciences."

9. Guide for Transporting the Ill and Injured

The Council had received with the agenda a guide for transporting the ill and injured, developed by the Division on Safe Transportation and recommended for approval by the Commission on State Departments.

On motion of Doctors Kief–Chojnacki, carried, the guide was approved by the Council.

10. Doctor's Housecall

A series of five-minute television films on health subjects, produced by a commercial firm, is being offered to television stations in Wisconsin. It is endorsed by the American Medical Association, with prior approval of scripts and sponsor categories. Mr. Hansen showed a sample film to the Council.

On motion of Doctors Dessloch–Chojnacki, carried, the Council approved the recommendation of the Commission on Public Relations and Communications that the Society endorse the series, subject to continued review by the AMA.

11. Reports of Council Committees

(a) Economic Medicine

Doctor Nordby reported one matter for Council action, relating to accreditation of nursing homes. He said that nursing homes nationwide and in Wisconsin are the subject of investigation of facilities, etc., for accreditation. The nationwide body for accreditation is a combination of the National Council for the Accreditation of Nursing Homes and the American Medical Association. The Division on Aging of the State Medical Society has recommended broad approval of an accreditation program which is not in conflict with the national program, and the National Council desires an expression of approval by the Society.

On motion of Doctors Nordby–Bell, carried, the recommendation was approved by the Council.

(b) Planning Committee

Doctor Frank presented the following report of its May 10 meeting:

(1) *Relationship with Osteopathy*

Chairman Frank and Doctor Davis had represented the committee in conference wth Doctors Allen and Johnson, representatives of the Wisconsin Association of Osteopathic Physicians and Surgeons, and their attorney, on March 21. The committee heard their report and reviewed the status of the relationship between physicians (M.D.s) and osteopaths, when it was reminded that the osteopaths are seeking recognition of professional status, the advantage of postgraduate education, and the opportunity to consult—to obtain written consultations and help in treating their cases.

After a good deal of discussion, and particularly around the fact that reactions vary throughout the state and the general feeling that local attitudes should carry weight, the committee recommended

that *as osteopaths are accepted locally*, they be included in any state level postgraduate and other similar scientific conferences being held by the State Medical Society.

The committee was advised that a meeting on this subject is scheduled during the June 1964 meeting of the American Medical Association, and it recommended that Doctor Frank, as chairman of the Planning Committee, be requested to observe this program at Society expense.

(2) *Clinical Psychology*

The committee reviewed briefly the status of a legislative proposal regarding clinical psychologists, as to licensure or certification and their qualifications.

Since a specific recommendation and evaluation of the problem was not available from the Commission on Public Policy, the Planning Committee felt it should request one—with particular emphasis on a medical appraisal of the matter—from the Commission on State Departments and its Division on Nervous and Mental Diseases, before proper action could be recommended to the Council.

(3) *Medical Student Orientation Programs at SMS*

The committee sees the advisability and advantage of a long-range program to educate the medical student, both at Marquette and Wisconsin, in matters of an economic character as related to their future practice of medicine, which are not available as such in medical school curricula.

As Doctor Kief pointed out, a rather complete program should be developed on an annual basis, and he suggested that this type of "orientation" could be provided not once, but in each year of medical school and on various aspects of medical economics.

The committee requested that Doctor Kief work closely with the staff in developing such a program and investigating existing programs in this field. As recommendations are developed they will be reported back to the Council, through the Planning Committee, for action.

(4) *Medicine and Pharmacy*

Doctor Davis reported on his attendance at the AMA Conference on Pharmacy and Medicine in March.

In view of additional meetings on the subject, scheduled for the June AMA meeting, the Planning Committee felt it could do no more at this time than receive the report of Doctor Davis, with the recommendation that it be permitted to reconsider the subject for subsequent report to the Council after the AMA meeting.

(5) *Future Meeting*

The heavy schedule on this date did not permit consideration of other specific items and pending matters of the Planning Committee, and it recognized the necessity of scheduling a separate meeting late in June, with enough time to handle the many subjects referred to it.

(c) Executive Committee

Doctor Egan presented the following report of its May 9 meeting:

The Executive Committee met Saturday afternoon and early evening. One item which has been on its agenda is the organization of an association of professions similar to that which exists in Michigan. The staff has been directed to prepare proposed constitution and bylaws for further consideration and in due course the matter will come to the Council.

The committee gave preliminary approval to program content for the 1965 Work Week of Health.

Arrangements were approved for the showing of a film on how physicians can engage in expressing their interest in matters of political action. This will be shown immediately following adjournment of the House of Delegates, first session.

These matters are referred to the Council:

(1) *Proposed resolution on treatment centers for alcoholics*

This was presented by Doctor MacCornack of Whitehall and the Executive Committee agreed that a problem exists but felt the resolution perhaps did not go far enough, and recommended that it be referred to the Planning Committee for further development.

On motion of Doctors Dessloch–Van Hecke, carried, the resolution was referred to the Planning Committee, the House to be so notified, and Doctor MacCornack to be invited to meet with the committee.

(2) *Action on dues at interim meeting of House*

On motion of Doctor Chojnacki, seconded and carried, the Council agreed with the committee that the matter of dues is by action of the House of Delegates a topic for the fall meeting.

(3) *Council meeting schedule*

A meeting schedule for the Council was recommended by the committee as follows:

February-March—2-day session
May—2 one-day sessions (plus attendance at annual meeting)
July-August—2-day session
October-November—1-day session (plus attendance at House)
Mid-December—1-day session

On motion of Doctors Dessloch–Hollenbeck, carried, this was approved by the Council, and the dates of October 9–10 were recommended for the 1964 interim session.

(4) *Eau Claire–Dunn–Pepin resolution*

Doctor Frank had presented a resolution to the committee, which referred it to the Council, relating to statutory provisions for welfare patients with a diagnosis of psychosis or tuberculosis.

Following discussion, it was referred to the House without recommendation on motion of Doctors Dessloch–Van Hecke, carried, Doctor Nordby voting in the negative. (See House proceedings, resolution 41 transmitted in report of Council.)

12. Resolution on Animal Research

Doctor Collentine requested Council introduction to the House of a resolution opposing federal regulations of animals in research, reiterating the position taken in 1963 on similar legislation before the Congress.

On motion of Doctors Nordby–Chojnacki, carried, it was forwarded to the House with approval of the Council. (See House proceedings, resolution 42 transmitted in report of Council.)

13. Closed Chest Cardiac Resuscitation

The Wisconsin Nurses Association had recently forwarded a revised version of a joint policy statement, initially presented to the Council in March by the Committee on Clinical Medicine, and tabled at that time in light of information that the nursing association wished to reconsider it.

On motion of Doctors Dessloch–Blanchard, carried, the following statement was approved:

"Closed chest cardiac resuscitation is normally an act of medical practice. When a physician is available, or as soon as a physician arrives, he should take charge of the treatment of cardiac arrest. When a physician is not present, one should be summoned and the attending physician notified as soon as circumstances reasonably permit.

"In the absence of a physician and until a physician arrives, a professional nurse, if specially trained in recognition of cardiac arrest and the technique of closed chest cardiac resuscitation, may promptly apply the appropriate procedure as an emergency measure.

"Each hospital and health agency should determine policy as to whether its professional nurses are to function in cardiac arrest emergency and to provide or provide for the requisite special training for its professional nursing staff if its nurses are expected to function in such procedure, and such special training shall be taught by or under the direction of physicians thoroughly familiar with the technique as well as with the related problems and limitations."

14. Resolution Proposed by President Egan

Doctor Egan presented a resolution calling for a non-medical advisory committee of six to investigate the problems and formulate recommendations as to future operation of the Blue Plans in Wisconsin.

On motion of Doctors Nordby–Chojnacki, carried, it was tabled by the Council, Doctor Van Hecke voting in the negative.

15. Survey Study Committee

Doctor Callan informed the Council that a supplementary report would be made to the House by Doctor Griffith, transmitting an independent legal opinion the committee had secured from Quarles, Herriott and Clemons, because of its uncertainty as to the respective authority and functions of the House of Delegates and the Council with respect to certain recommendations in the Booz, Allen and Hamilton report.

This opinion had previously been sent to the Council by Doctor Callan.

Doctor Fox announced that he had requested Mr. Murphy, general counsel, and Mr. Kluwin, associate general counsel by appointment of the Council, also to prepare an opinion on the legal relationships of the membership, the House, and the Council of the State Medical Society.

The opinion by Society counsel was made available to those in attendance, and the information and communication provided by Doctor Callan were received and placed on file, on motion of Doctors Van Hecke–Kief, carried.

16. National Medical Foundation for Eye Care

Doctor Nadeau presented a request of the Section on Ophthalmology and Otolaryngology that the Society affiliate itself with the National Medical Foundation for Eye Care. There was insufficient information available to the Council for action.

On motion of Doctors Nordby–Mason, carried, the subject was placed on the table.

17. Section Dues

Mr. Crownhart reported a recent request from Doctor Bolger for an opinion as to whether scientific sections of the Society could impose a dues structure upon its members, to be used for educational purposes. He had not had opportunity to reply formally, but expressed his opinion that a section could set up a dues structure, subject to approval by the Council, and a major consideration would be whether it was within reason and not of such character to inhibit membership in the section.

18. Adjournment

The meeting adjourned at 5:10 p.m. with announcement that the Council would meet upon adjournment of the House Tuesday morning.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman

Minutes of Council Meeting

MILWAUKEE, MAY 12, 1964

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 10:10 a.m. on Tuesday, May 12, 1964, at the Hotel Schroeder in Milwaukee.

Voting members present were Doctors Schulz, Nordby, Davis, Stoops, Dessloch, Blanchard, Nadeau, Fox, Bell, Mason, Frank, Lee, Chojnacki, Hollenbeck, Van Hecke, Wright, President Curran, Past President Egan, and Speaker Callan.

Officers and others present: President-elect Houghton, Treasurer Weston, Vice Speaker Behnke, Doctors Bernhart, Quisling and Galasinski, AMA Delegates; Doctors Hildebrand and Picard, Alternate Delegates; Past President Hill; John Medelman, M.D., President, Minnesota State Medical Association; Messrs. Crownhart, Murphy, White, Tiffany, Kluwin, Toser, Koenig, and Hansen; Mrs. Anderson and Miss Pyre.

2. Introductions and Oath of Office

Chairman Fox introduced John Medelman, M.D., President of the Minnesota State Medical Association; Howard J. Lee, M.D., newly elected councilor from the twelfth district; George A. Behnke, M.D., Vice Speaker; and J. H. Houghton, M.D., President-elect.

He then administered the oath of office to Doctors Lee and Behnke.

3. Organization of State Medical Society

Doctor Fox announced that he was not in a position to decide immediately on appointments to the various Council committees, but would send notification of them.

He called upon Secretary Crownhart to present the organization of the State Medical Society, which

was done by slide projection, showing the composition of the House of Delegates, the Council, election of officers, appointment of consultants, membership of Standing and Council Committees, the structure of the SMS Realty Corporation, the Charitable, Educational and Scientific Foundation, Section on Medical History, and liaison with county medical societies.

Mr. Crownhart called on Mr. Toser, who announced the appointment by a committee delegated by the Commission on Medical Care Plans, of Mr. R. E. Koenig as Insurance Director. Mr. Toser will continue in a consulting capacity.

Doctor Fox then reviewed appropriate provisions of the Constitution and Bylaws relating to duties of councilors.

Doctor Chojnacki raised a question on authority required for appointment of an insurance director. Doctor Fox responded that the Council had reaffirmed the position on a full-time basis, and the secretary and Commission may fill it.

4. Election of Officers

On separate motion duly made, seconded and carried, the following were nominated and unanimously reelected.

Chairman of the Council—James C. Fox, M.D., La Crosse
Vice Chairman of Council—John M. Bell, M.D., Marinette
Treasurer of the Society—F. L. Weston, M.D., Madison
Assistant Treasurers—H. Kent Tenney, M. D. Madison; John T. Sprague, M.D., Madison; E. J. Nordby, M.D., Madison
Secretary and General Manager—Mr. C. H. Crownhart, Madison
Editorial Director—D. N. Goldstein, M.D., Kenosha
Medical Editor—Victor S. Falk, Jr., M.D., Edgerton
Consulting Editor—R. S. Baldwin, M.D., Marshfield

5. National Medical Foundation for Eye Care

Doctor Nadeau said he had acquired more information on the request of the Section on Ophthalmology and Otolaryngology, which was that it be permitted to affiliate with the National Medical Foundation for Eye Care. Council authorization was required since the Section is not an autonomous body. At least five other state societies have so authorized their ophthalmological sections.

On motion of Doctors Nordby-Bell, carried, such affiliation was approved provided its actions are not binding upon the State Medical Society; there are no fiscal implications; and the right is reserved to withdraw at any time.

6. Resolution 41

Doctor Nordby pointed out that in one resolution adopted by the House in the session just concluded, unequivocal opposition was expressed to King-Anderson and similar legislation. Resolution 41, also approved, is contradictory in that it encourages the use of government funds for welfare patients with a diagnosis of psychosis or tuberculosis. He felt it was incumbent upon the Council to screen more carefully matters that come in late for introduction through the Council.

7. Executive Session

Doctor Schulz presented a communication from a constituent which was discussed in executive session.

8. Adjournment

The meeting adjourned at 11:45 a. m.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman

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the wisconsin medical journal

VOLUME 63/NUMBER 10 OCTOBER 1964

LEPTOSPIROSIS:

Case Report and Review of Recent Literature

By MAX J. FOX, M.D. and JOSEPH E. PILON, JR.

Milwaukee, Wisconsin

■ OCCASIONALLY one gets the idea that one has been "spoofed" by Mother Nature.

According to Koch's Postulates, one must (a) find the organism associated constantly with the clinical disease, (b) isolate it in pure culture, (c) reproduce the disease in experimental animals, and (d) recover the organism in pure culture from the infected experimental animal. In the following case report, the evidence in the history suggests that Mother Nature (perhaps "miffed" by the indifference of U.S. physicians to her obsequious phantom) turned the tables by using man as the "experimental animal" to establish L. pomona infection in chickens.

CASE REPORT. A 16-year-old white boy entered the hospital in June, 1963 with a two-week history of abdominal cramps, nausea, vomiting, and diarrhea. The onset had been sudden and vigorous, relenting but briefly during the two-week period. On the day prior to admission the patient had suddenly become jaundiced. The lad divulged that he was from an area of the city undergoing development and on the premises there were a well, an outhouse, and a chicken coop. He related that it was his duty to tend the chickens, and it was the custom of the family to sell the good eggs and keep the cracked eggs for home consumption. The remainder of the history was essentially negative.

Physical examination revealed a markedly icteric youth with a temperature of 99.6 F. orally; pulse rate 64; respirations 18 per minute. The liver was enlarged and slightly tender with a palpably smooth border. Skin and sclerae were icteric. There was no skin rash, gross adenopathy, or meningismus. The remainder of the physical examination was essentially normal.

Laboratory tests done the second day revealed bilious urine with a trace of albumin and a strongly positive ictotest; the stool was clay colored. The white blood cell count was normal with moderately elevated monocytes (14%); sedimentation rate was 12 mm. per hr.; serum bilirubin was 12.5 mg. per 100 ml. There was + + + cephalin flocculation in 24 hours, a serum glutamic oxalopyruvic transaminase (SGO-T) level of 308 units, and alkaline phosphatase of 16.4 Bodansky units. The test for syphilis (VDRL) was nonreactive. Complement fixation and heterophil agglutination tests were negative. Serologic studies for leptospiral antibodies were 1:128 for L. pomona and negative for L. canicola, L. icterohemorrhagiae, L. grippotyphosa and L. mitis. Brucella, typhoid, paratyphoid, and tularemia agglutination tests were negative except for a questionable 1:20 positive titer for Paratyphoid B "H" antigen. The chest x-ray film was interpreted as normal.

The patient's temperature responded to aspirin therapy in the first 24 hours and remained normal throughout the remainder of his hospital stay. A bradycardia and associated irregularity was noted several times during the first ten days of hospitalization but regular rate of 56 or more per minute was noted thereafter. The jaundice was observed to worsen during the first 72 hours but then gradually cleared to complete absence four days prior to discharge on the fifteenth day. A blood specimen drawn at the time of discharge revealed marked increase in L. pomona antibody titer to 1:2048 but was negative for L. canicola, L. icterohemorrhagiae, L. grip-

Doctor Fox is an Associate Professor of Internal Medicine at Marquette University School of Medicine and a past preceptor to the University of Wisconsin Medical School.

Mr. Pilon is a senior medical student at Marquette University School of Medicine, a junior at the time this paper was written.

potyphosa and L. mitis. Brucella agglutination studies performed at the same time were completely negative (Fig. 1).

Comment. There is considerable disagreement in the literature concerning leptospirosis infection in chickens. In Germany, Uhlenhuth and Fromme[1] claim to have proven that chickens are resistant to infection by Leptospira. However, more recent workers have demonstrated that chickens show a high titer of leptospiral agglutinins in the serum. Pertinent to our presentation is the work of Gillespie *et al.*[2] and Chalquest[3] who demonstrated L. pomona infections in chickens. Leptospira grow readily on the membranes of the developing chick embryo and kill the embryo in less than seven days. It is our belief that the lad contracted his disease from eating cracked chicken eggs inoculated by a hen harboring the organism.

Discussion. Although Landouzy first reported his observation in 1883, Weil is credited with first describing the syndrome, which now bears his name, in 1886[4] when he published a vivid account of four closely similar, nonfatal, sporadic cases that developed during the summer months in persons of different professions. These patients suffered illnesses characterized by fever, severe mental confusion, myalgia, jaundice, nephritis, hemorrhages, febrile relapses, and a late complication of uveitis. Inada and Ido *et al.*[5] in 1914 and Uhlenhuth[22] in 1915, working independently, established that the etiologic agent in "Weil's disease" was spirochetal in nature. Following close on their cultures, Noguchi[23] in 1917 isolated an organism from a case of jaundice which he compared with the organisms isolated by Inada and with others isolated from rats in the United States, found them to be identical and identified this new genus as "Leptospira" (Gr. meaning "thin coil").

In subsequent decades, leptospirosis was viewed by physicians in the United States as a disease occurring in "other countries" and reports of the disease in this country lagged far behind the incidence reports from the rest of the globe. One cannot survey the literature without consistently finding an author chastising U. S. physicians for their ill-taken lack of interest in cases of leptospirosis passing undiagnosed underneath their very noses.

Between 1905 and 1941 there were 93 cases reported in this country; between 1941 (the year Ashe[6] published his excellent review on

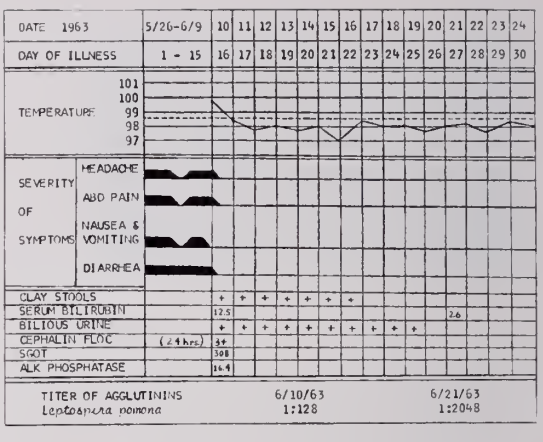

Fig. 1—Case report, course of illness.

the subject) and 1948, there were 206 cases reported. Once again the literature was reviewed, notably by Broom,[7] Edwards,[8] Galton,[9] and Stockard,[10] and between 1953 and 1960 there were 601 cases reported (Table 1). However, according to the serologic studies of random populations by Tiffany and Martorana in New York[11] and Nimlos in Milwaukee,[12] reported cases fell far short of the predicted incidence. Predicated on the results of her studies, Nimlos predicted that the incidence in the population of greater Milwaukee amounted to some thousands (one-third of a per cent). There was *one* reported case of leptospirosis in Milwaukee during the year of her study. The New York group had a comparable experience.

The reader may well ask: "Why the disparity?". A number of reasons were proposed by Bertucci[24] in 1945 for the failure of the disease to be recognized more frequently on this continent. These were: (1) a poor description of the disease in American textbooks, (2) city and state laboratories unequipped to make the diagnosis properly, (3) physicians consider the disease too rare to include it in their differential diagnosis, (4) few physicians are aware of the fact that not all cases present with jaundice, and (5) even when the disease is suspected, care is not taken to isolate the organism during the proper stage of the disease. Several steps have been taken since to correct the above situation but the problem remains obviously far from solved.

The Organism. Leptospira are thin, tightly coiled organisms measuring 7–20 u. long and 0:10 to 0.2 u. in diameter. They are relatively fastidious and grow best in slightly akaline

TABLE 1—*Reported Outbreaks of Leptospirosis in the United States*

Date of Onset	Location	No. of Cases	Age Range	Probable Source[1]	Serotype Involved
July, 1939	Near Philadelphia, Pa.	7	Young adult males	rats(?)	*L. icterohemorrhagiae*[2]
August, 1940	Wrens, Ga.	35	Av. 16	cattle	*L. pomona**
July, August, 1942–43–44	Ft. Bragg, N. C.	40/yr.	Young adults (soldiers)	unknown	*L. autumnalis*
August, 1942	Jackson Hole, Wyo.	24**	15–19	dogs, deer or other animals	*L. canicola*
August, 1947	Calvary, Ga.	10	13–24	dead mule in creek (?)	(?)
August, 1949	Swainsboro, Ga.	12	Young adults	cattle	*L. pomona**
July, 1950	Geneva, Ala.	50	Adolescents	swine	*L. pomona**
July, 1952	Columbus, Ga.	26	Young adults 5–20 2 adults	swine, dogs and cattle	*L. canicola*
July, August, 1956	Wakpala, S. D.	3	Young adults	cattle, swine or wild animals	*L. pomona**
July, 1958	Madison, Fla.	8	Children	swine*** and cattle	*L. pomona*
August, 1959	Cedar Rapids, Ia.	42	Children and adults	cattle	*L. pomona*

[1]With the possible exception of the Fort Bragg outbreaks, all were attributed to swimming in contaminated water.
*Serologic evidence only.
**Nine confirmed serologically.
***L. *pomona* isolated from swine, serologic evidence in cattle and human cases.
[2]Organisms recovered from blood of one fatal case.
(From Galton, M. M. and others: Leptospirosis; Epidemiology; Clinical Manifestations in Man and Animals, and Methods in Laboratory Diagnosis. Public Health Service Publication No. 951, U. S. Government Printing office, 1962.)

media (pH 7.2) at a temperature of 25 to 30 C.

Distribution. In nature, Leptospira organisms have been recovered from virtually every portion of the globe but are most prevalent in temperate and subtropic zones. Their chief reservoir is the kidney of the common rat, but other animals in the United States known to harbor Leptospira include dogs, cattle, swine, skunks, raccoon, wildcat, oppossum, mice, and gray fox. Outside the living host their survival depends upon maintenance of a moist, wet environment with low bacterial contamination and neutral to slightly alkaline pH. They can withstand freezing and have survived below the surface of sugar cane fields which have been burned to the ground. Man is a purely incidental and nonessential link in their life cycle.

Classification. Because of their morphologic similarity the Leptospira organisms are not grouped but are serologically subtyped according to their antigenic specificity.

The Disease. *Terminology.* The list of synonyms for leptospirosis is a veritable potpourri of causative serotypes, seasonal variants, cities of discovery and eulogistic eponyms, and the use of same has undoubtedly been a contributing factor underlying the lack of universal interest in the disease.

The synonyms, such as "Weil's disease," "Fort Bragg fever," "pretibial fever," "swineherd's disease," "swamp fever," "cane field fever," to mention a few, should be discarded in favor of the more universal nomenclature: "Leptospirosis due to ———" with interjection of the appropriate causative agent.

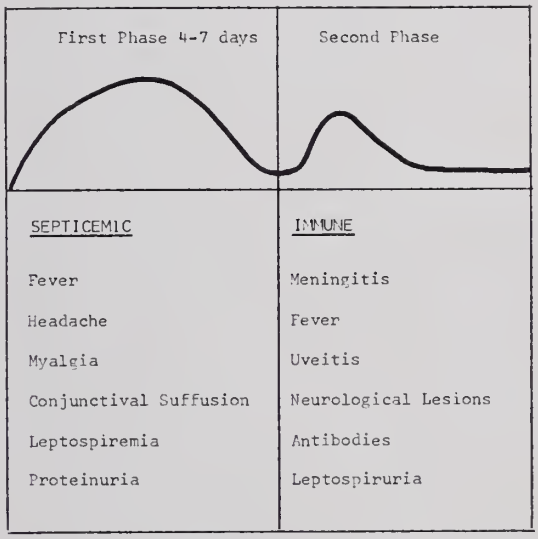

Fig. 2—Stoges of leptospirosis. (From Edwords, G. A. and Domm, B. M.: Medicine 39:117, 1960)

Definition. Leptospirosis is an acute, self-limiting, biphasic disease caused by a variety of known pathogenic serotypes (not all Leptospira organisms are pathogenic). The basic pattern of the disease is illustrated in Figure 2. Typically the disease has two forms, severe or mild, depending upon the infecting serotype.

Transmission. Leptospira organisms are believed to gain entry into humans through mucous membranes or openings in the skin but not through the skin itself. The most usual mode of infection is contact with contaminated bodies of water. Typical examples are the epidemics occurring in civilians who dived into the Amsterdam Canal during the

bombing of The Netherlands in World War II and in a group of lads in Georgia who were swimming in a slow moving river in which dead hogs had been seen floating just a short time before. Sporadic cases are reported in sewer workers, individuals handling pigs, and other workers in animal husbandry to mention a few. There is a case reported in a farmer who gave mouth-to-mouth resuscitation to piglets sick with the disease.

Clinical Manifestations. For a list of representative clinical manifestations and their percentages of occurrence see Figures 3 and 4.

FIRST STAGE: Following an incubation period of 2 to 19 days, the onset of the disease is usually sudden and vigorous (heralded as the "brutal beginning"). The first stage of the disease has the clinical manifestations of an acute septicemia and leptospiral organisms may be isolated from the blood. The main manifestations are headache, retrobulbar pain, photophobia, muscle aching, arthralgia, shaking chills and fever, abdominal pain, nausea and vomiting, and cough. The patients appear acutely uncomfortable and are sometimes confused and delirious. Conjunctival injection is the most common and characteristic physical finding with a variable percentage of patients also showing some of the following signs: pharyngeal injection, lymphadenopathy, hepatomegaly, splenomegaly, muscle tenderness, rales, nuchal rigidity, rash, hemorrhagic herpes labialis, hemorrhagic tendency, jaundice, hypotension, bradycardia, and cardiac arrhythmias. Unusual manifestations include acute arthritis, parotitis, epididymitis, testicular pain, myocarditis, gross hematuria, nephritis, and pancreatitis. The patient is left exhausted at the end of the first stage; however, death is rare during this stage.

SECOND STAGE: The second stage, in contrast to the monotonous clinical picture of the first stage, is a stage of extreme variability. Typically, the first stage is followed by a brief asymptomatic afebrile period of 1 to 3 days, after which fever recurs and meningitis appears. The fever is usually less severe and of shorter duration. Meningitis occurs in 80 to 85 per cent of these cases and may be subclinical, mild, or quite severe, and lasts from 1 to 14 days. Less common manifestations of the second stage are rash, iridocyclitis, alopecia, endocarditis, and various neurologic problems.

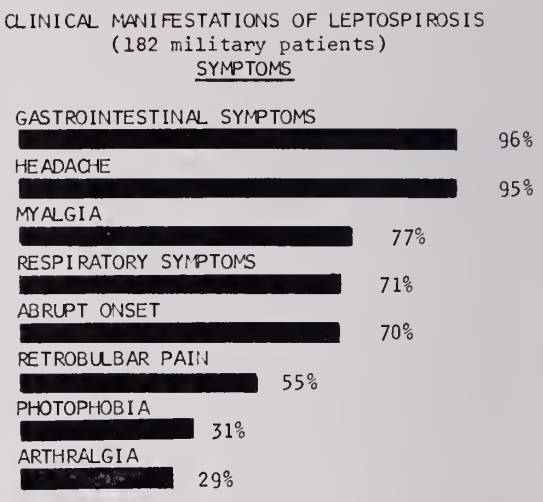

Fig. 3—Salient subjective findings in military patients with leptospirosis. (From McCrumb et al.: Trans. Assoc. Am. Phys. 49:122, 1956)

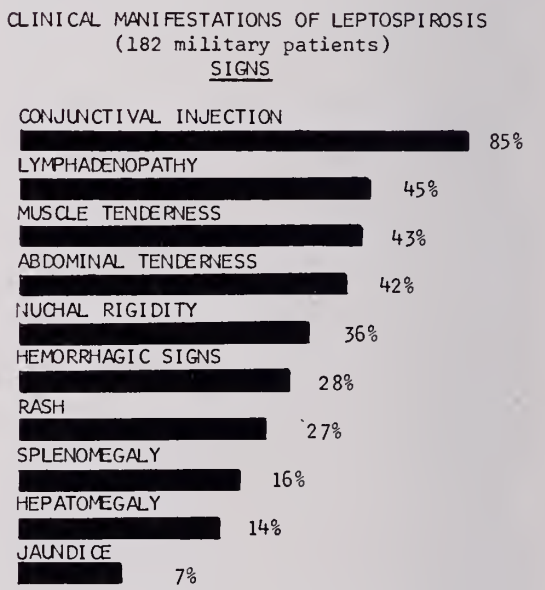

Fig. 4—Objective clinical manifestations of leptospirosis in military patients. (From McCrumb et al.: Trans. Assoc. Am. Phys. 49:122, 1956)

Sequelae. The most common sequela to acute leptospiral infection is iridocyclitis occurring from one month to a year following infection.[13] Reports of this phenomenon are

much more frequent in foreign literature, although it is believed to occur just as frequently in the United States. Other less commonly occurring sequelae are temporary baldness (partial or complete), vegetative endocarditis, myocarditis, and parotitis.

Weil's Syndrome. About 5 to 10 per cent of cases of leptospirosis present with the severe clinical manifestations described by Weil. The onset of this severe form is characterized by such features as jaundice, hemorrhage, collapse, and renal problems about the third to fifth day (during the first stage), but they do not reach their peak intensity until well into the second stage and may therefore obscure the end of the first stage. Fever is more marked and may persist for several weeks.

Prognosis. For the most part, prognosis is dependent upon two factors; i.e., the virulence of the infecting organism and the age of the patient. Of the two the former is more important. As a rule, however, the patient either conquers his disease or succumbs to it; there are no chronic components to the disease reported. Deaths in the anicteric form of the disease are virtually unknown. In several series, however, mortality rates between 15 and 40 per cent have been reported in the icteric form of the disease.[14,15]

Morbid Anatomy. Pathologic changes are noted most frequently in the kidney, liver, heart, and skeletal muscles. The most severe changes are in the kidney. Hemorrhages of the skin, mucous membranes, and viscera are common. The liver is enlarged and exhibits evidences of parenchymal degeneration with focal necrosis. Lesions resemble acute yellow atrophy.

The kidneys are swollen and show degenerative changes of the convoluted tubules with necrosis and casts. Glomeruli are often swollen and filled with exudate and bile precipitate; the capsular endothelium is proliferated. There is infiltration with lymphocytic and mononuclear cells between the tubules, and hemorrhages are frequent.

Diagnosis. From the protean manifestations enumerated above, it is obvious that the first step in making the diagnosis of leptospirosis is the suspicion of the disease. This can very often be made from the epidemiologic factors involved. As evidenced by the case history, the history is practically the sine qua non of suspecting the diagnosis. The disease is most often confused with meningitides of viral origin, poliomyelitis, influenza, mumps, typhoid fever, brucellosis, or tuberculosis.

At present, the diagnosis rests on laboratory tests. The most commonly used test is that employing live Leptospira and patient's serum. Microscopic visualization of agglutination establishes the diagnosis. Agglutination occurring in single titers of 1:300 is considered significant. However, most laboratories prefer the criteria of demonstrating at least a fourfold rise in specific antibody titer between acute and convalescent sera.

If one wishes to culture the organism, it is imperative that blood samples be drawn during the first week of the illness and urine samples used thereafter. Steps should be taken to insure the patient is excreting alkaline urine because of the high susceptibility of the organism to acid. Leptospira grow slowly in vitro; about one third of cultures are positive in 7 to 10 days, one half in 2 weeks, and the rest in 4 to 6 weeks total incubation time. Thus cultures should not be discarded before 6 weeks have elapsed.

McCrumb *et al.*[14] required satisfaction of one or more of the following criteria for the laboratory diagnosis of leptospirosis: (1) isolation of leptospires from the blood, (2) fourfold or greater rise in complement fixing or agglutination-lysis antibody titers, or both, during the course of the illness, and (3) sustained titer of 1:40 or greater by complement fixation, or 1:400 or greater by agglutination-lysis when the first serum specimen was obtained on or after the seventh day of illness.

Cox[16,17] has reported a hemolytic test based on the ability of leptospiral extracts to sensitize sheep erythrocytes so that hemolysis occurs in the presence of leptospiral antiserum and complement. Since the property of sensitization is possessed by all Leptospira, both pathogenic and nonpathogenic, an extract of the nonpathogen, L. biflexa, is used thereby reducing the hazard to laboratory personnel. It is reported to be highly sensitive and simple, broadly specific, and to be less time-consuming than the standard microscopic agglutination test. For an excellent, comprehensive treatise on the laboratory diagnosis of leptospirosis the interested reader is referred to the work of Gouchenour *et al.*[18]

Therapy. Current therapy centers about supportive care and the use of the more potent analgesics such as codeine. Aspirin is re-

ported to be ineffective in the headaches and myalgia attending the acute phase of the disease. Although it is known that antibiotics have an inhibitory effect on the organism in vitro, most workers report their efficacy as highly questionable in vivo. Hall *et al.*[19] discounted the use of chlortetracycline, oxytetracycline, chloramphenicol, streptomycin, or penicillin alone or in combinations. Fairburn and Semple[20] also concluded that none of the known antibiotics appear to alter dramatically the clinical course of leptospiral infections in man under all conditions, but chlortetracycline, oxytetracycline, or penicillin may possess some therapeutic value when administered in adequate doses beginning shortly after the onset of symptoms. However, Liebowitz,[21] reports a dramatic clinical improvement following administration of oxytetracycline hydrochloride after failure to respond in any way to treatment with penicillin.

Summary. A case of leptospirosis due to L. pomona has been reported. It is believed the infection was contracted by the ingestion of cracked chicken eggs inoculated by a hen harboring the organism.

Serologic studies indicate that leptospiral infections in man are far more prevalent than case reports of the disease would indicate. The cause of this disparity was discussed.

A synopsis of the recent literature was presented with particular attention given to current diagnostic methods and therapy. From our review of the subject, it is our belief that the overwhelming disproportionate ratio of leptospirosis incidence to leptospirosis diagnosis may be overcome by: (1) a higher suspicion of the disease than is presently "in vogue," (2) proper attention to the securing of appropriate specimens at the opportune time of the disease, and (3) prophylactic disposal of the confusing thirty-odd synonyms for the disease with referral in the future to all cases as "leptospirosis due to ——" with interjection of the appropriate causative organism, if known.

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Hemangioendothelial Sarcoma of the Liver (Kupffer Cell Sarcoma)

CASE REPORT

By E. A. MILLER, M.D., W. G. RICHARDS, M.D., and W. H. REED, M.D.
Watertown, Wisconsin

■ HEMANGIOENDOTHELIAL sarcoma of the liver is a rare lesion. Two types are usually distinguished: the infantile and the adult. The adult type has characteristics which differ radically from the infantile type. This report is limited to the adult type. Besides being more malignant from its onset and having a 100 per cent mortality, the adult type seems to take its origin from the sinusoidal endothelium; and many malignant cells have the characteristics of Kupffer cells. For this latter reason the term Kupffer cell sarcoma has been proposed.

Twenty-five cases were reported up to 1956.[1,2] Three cases were reported by Baker in 1956.[1] Since then only three cases have been reported: one by Burston in 1958,[3] another by Layton in 1959,[4] and the third by Davis in 1961.[5] To date this makes 31 cases reported.

Other synonyms for this lesion include: angioblastic sarcoma, angioplastic sarcoma, angiosarcoma, reticuloendothelioma, and endothelioblastoma.

Case Report. A 67-year-old white woman was admitted to the hospital in January 1963. Four days before admission she was seen by her physician at home because of pain in her side. The patient was difficult to question because her answers were not always appropriate or even forthcoming. She had a history of mental difficulties, and five years previously she had had a mental lapse which, according to her husband's information, must have been a psychotic state.

She had no fever or nausea; her only complaint was pain in her right side. She was somewhat tender to palpation over the gallbladder, but there were no palpable masses and no jaundice was noted. The examination was not entirely satisfactory and admission to the hospital was advised.

Four days later she was admitted to the hospital with the same complaint of pain in her right side. She was placed at bed rest and 2 ml. of dihydrostreptomycin and penicillin (Combiotic) were given intramuscularly daily. Dextropropoxyphene with acetylsalicylic acid (Darvo-Tran) was given every four hours, and 0.1 Gm. of pentobarbital sodium (Nembutal) was given for sleep. Her temperature on admission was 97.0 F., blood pressure 122/62 mm. Hg., pulse rate 90 per minute. Her hemoglobin level was 12.1 Gm. per 100 ml., hematocrit reading 39%, white blood cell count 26,600 per cu. mm. with a differential of 72 segmented cells, 17 band forms, 5 lymphocytes, 3 monocytes, and 3 eosinophils. Urinalysis was normal. Blood urea nitrogen was 12 mg. per 100 ml.

On admission a chest x-ray film revealed: "suspected minimal pneumonitis at the right base and slight elevation of the right hemidiaphragm." In the next few days there was a slight elevation of her temperature to 99.6 F., and the marked neutrophilic leukocytosis persisted. A mass developed in the right upper quadrant which was thought to be inflammatory in origin and related to the gallbladder. A cholecystogram, taken six days after admission, failed to reveal any gallbladder shadow. A 1.0 cm. ring-shaped shadow of calcific density, noted in the region of the gallbladder, was suspected to be a gallstone. No other masses were noted in the area.

A liver profile at this time showed a normal thymol turbidity, direct bilirubin 2.5 and indirect bilirubin 1.5 mg. per 100 ml., alkaline phosphatase 17.8 King-Armstrong units, albumin 3.2 and globulin 3.4 Gm. per 100 ml., prothrombin time 100% of normal, stool bile positive, urine bile negative, urobilinogen positive 1:64.

Her temperature rose to 100.5 F. in the next few days. Although her general condition was fair, her appetite was poor. She was extremely stoical and had an inadequate re-

sponse to her illness. She appeared weak and pale but voiced no complaints.

An upper gastrointestinal x-ray series, taken nine days after admission, showed two areas of subsegmental atelectasis in the right lung and resolving of the basilar infiltrate which had been noted on admission. A large, extragastric mass consistent with a subhepatic abscess was described. There was nonvisualization of the gallbladder with cholelithiasis and an elevated, restricted, right hemidiaphragm. The white blood cell count had risen to 35,200 per cu. mm. with a marked neutrophilic leukocytosis and a shift to the left with toxic granulation.

A surgical consultation was obtained. The impression of the consulting surgeon was subhepatic abscess probably secondary to cholecystic perforation. A neoplasm of the portal region with areas of necrosis was to be ruled out. The patient was prepared for a drainage of a subhepatic abscess with or without biopsy and choledochostomy. She received transfusions of whole blood, parenteral vitamins B and K and hydration. Local infiltration anesthesia supplemented by nitrous oxide inhalation was used, and the right upper quadrant was entered through a transverse incision. This was carried down to the peritoneal cavity and the colon was identified and retracted from the field. An attempt was made to attach the peritoneum to a large inflammatory mass. A trochar was inserted into the mass, and a moderate amount of serosanguinous fluid was aspirated. Digital palpation of the aspiration tract revealed a large, solid, necrotic tissue mass without evidence of organized abscess formation. Some of the friable necrotic tissue was removed for biopsy, drains were inserted, and the wound closed.

The surgical pathology report revealed fragments of soft tissue showing fibrosis and marked necrosis. Some of the fibroblasts had large, irregular, hyperchromatic and somewhat atypical nuclei. No definitive architecture was present in any of the sections. The patient's condition deteriorated rapidly, and she died 22 days after admission.

At autopsy the skin was icteric and the abdomen was distended. The surgical wound in the right upper quadrant of the abdomen was clean with some evidence of healing. Drains were still present and some serosanguinous drainage was noted on the dressing. The remainder of the external examination was negative except for slight obesity. The peritoneal cavity contained 100 ml. of straw-colored fluid. Some fibrinous adhesions were noted in the region of the recent surgery in the upper abdomen. The stomach was pulled up tightly against a large mass in the gallbladder area.

The greater omentum was edematous, very firm, and adherent to the displaced stomach and to the gallbladder. A drain was found inserted beneath the omentum and some necrosis was present at the point of biopsy in the omentum overlying the mass. The omentum and stomach were pulled free from the undersurface of the liver. The gallbladder was very large and filled with 200 mixed-type stones varying in size from 0.3 to 1.0 cm. in diameter (Fig. 1). The cystic duct was impacted with these stones and occasional tiny stones were present in the common bile duct. The peritoneal surface was greenish-gray and had a thin 1.0 to 2.0 mm. wall. The hepatic surface of the gallbladder was very thick, measuring up to 1.0 cm. in some areas. A neoplastic lesion was infiltrating this surface by direct extension from the liver. The mucosa had lost its normal velvety texture and was rough, irregular and fibrous in appearance. The liver was enlarged to about 1⅓ times its normal size and had a mottled reddish-brown to purplish-brown appearance externally. On cross section it was friable and showed large areas of purplish-brown mottled discoloration in all lobes surrounded by areas of dark brown nutmeg appearance. The greatest alteration was in the right lobe. Gross areas of infarction were noted and many of the branches of the portal vein were filled with reddish-purple thrombi (Fig. 2). A few enlarged lymph nodes were palpable about the celiac axis. Two of these nodes were firm and grayish-purple on cross section. The heart and lungs were normal. The remainder of the abdominal organs showed no gross abnormalities.

On microscopic examination the sections of liver showed a neoplastic lesion arising from this organ which consisted mainly of many vascular channels, some filled with blood and lined by malignant endothelial cells (Fig. 3). Some of the cells resembled Kupffer cells and hyperplasia of sinusoidal endothelium was demonstrated in areas of liver surrounding the tumor. Large vascular spaces lined by malignant endothelial cells were noted with contingent areas of more solid anaplastic ma-

Fig. 1—Gross photograph of the gallbladder containing mixed type stones. Note the irregularity of the mucosa and the marked thickening of the hepatic surface.

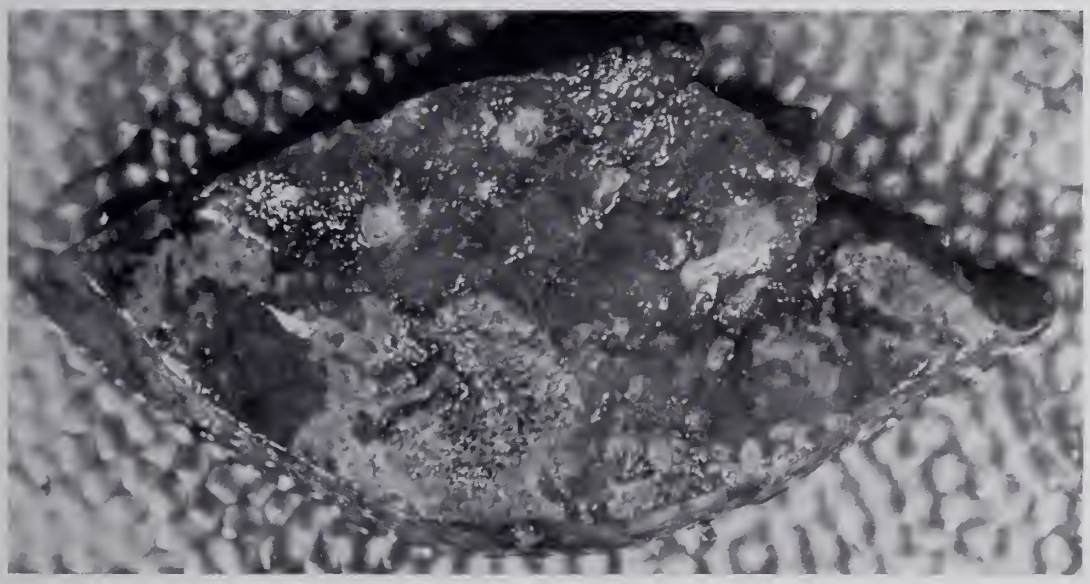

Fig. 2—Gross photograph of a section of liver showing reddish-purple neoplastic tissue with areas of thrombosis and infarction.

lignant growth. The malignant vascular endothelium was growing outward along the interlobular connective tissue and replacing normal endothelium in some areas. Tumor thrombi were noted with resultant infarction and necrosis of hepatic and tumor tissue. There was no fibrosis present.

Small foci of hematopoiesis were noted and some of the malignant cells showed phagocytic properties. Infiltration by direct exten-

sion into the gallbladder through the hepatic surface was noted and much of the wall and mucosa was replaced (Fig. 4). Metastases were also found in portions of the greater omentum and in a few celiac lymph nodes (Fig. 5). Special stains revealed no myofibrils in any of the sections. A microscopic diagnosis of hemangioendothelial (Kupffer cell) sarcoma of the liver was made.

Comment. Malignant tumors arising from the sinusoidal endothelium of the liver are uncommon. The adult lesion appears to be distinct and has a much poorer prognosis than the infantile form. Cirrhosis may precede the lesion. Thirteen of 31 cases thus far reported had some degree of cirrhosis and one had hemochromatosis. One case was reported in which ionizing radiation due to Thorotrast was given many years previously. Another case was reported in which gamma radiation from a lost radium needle was implicated.

It is fairly well accepted that the tumor does arise from the endothelial lining of the sinusoids and is distinct in its gross and microscopic appearance. It is probably best termed a Kupffer cell sarcoma as this nomenclature best describes its specific origin and its malignancy. Because of the multi-potentiality of the endothelial cells lining the liver sinusoids, the histologic picture of the tumor may be varied; and one sees fairly well differentiated hyperchromatic endothelial cells lining vascular channels with transition to frankly malignant endothelium and areas of spindle-shaped and anaplastic cells. Small foci of hematopoiesis are not uncommon and active phagocytosis by malignant cells is noted. Tumor thrombi with large areas of infarction and necrosis seem to be characteristic. Metastases have been mainly noted in the lungs but have also been described in the spleen, pancreas, celiac lymph nodes, omentum, and in one case the thyroid gland. Metastasis by direct extension into the gallbladder was seen in the case presented.

Summary. Hemangioendothelial sarcoma (Kupffer cell sarcoma) is uncommon but must be considered in the differential diagnosis of liver neoplasms. It arises from the endothelial lining of the liver sinusoids. Its three main microscopic characteristics, vasoformative, phagocytic, and hematopoietic, testify as to its origin from a multi-potential endothelial cell. Many of the malignant cells are distinctly of Kupffer cell type. It spreads locally by direct extension along the interlobular connective tissue replacing normal vascular endothelium. It can spread to the gallbladder through its hepatic surface.

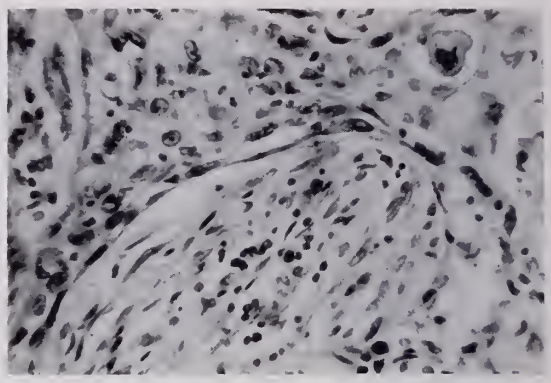

Fig. 3—Photomicrograph of liver showing a diffuse infiltration with malignant vascular endothelium.

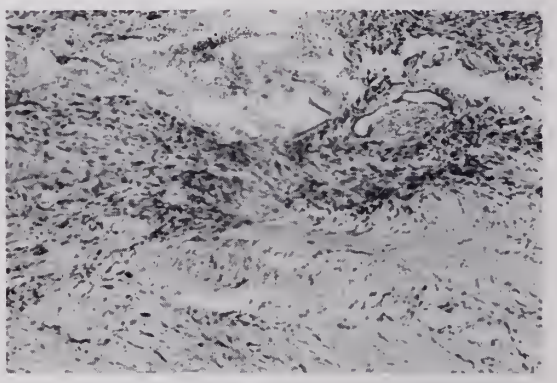

Fig. 4—Photomicrograph of gallbladder showing infiltration of malignant vascular endothelium throughout the wall and mucosa.

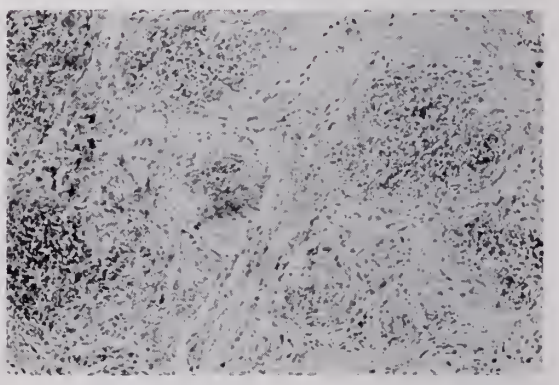

Fig. 5—Photomicrograph of lymph node from celiac axis showing diffuse infiltration with hemangioendothelial sarcoma.

Metastases have been reported in the lung and regional lymph nodes and occasionally in the spleen, pancreas, and omentum. In one case metastasis to thyroid gland was described. Tumor thrombi seem to be characteristic of the lesion and large areas of infarction and necrosis are produced accounting for some of the clinical symptoms and signs. The earliest symptoms are referrable to the gallbladder area, and the patient may undergo surgery for a cholecystitis with perforation. The fever and leukocytosis, probably caused by the tumor thrombi with resultant liver necrosis, gives some credence to this impression. Late icterus and early death in hepatic coma seem to be other prominent clinical features.

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106 West Main Street.

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Compounding of Symptoms with Prochlorperazine (Compazine)

By GLENN A. BACON, M.D., Racine, Wisconsin

■ THE EXTRAPYRAMIDAL side effects of the phenothiazine derivatives have been known to physicians for many years. Their full blown manifestations include: (1) tremor, (2) rigidity, (3) trismus, (4) dystonic movements of the extremities, (5) sialorrhea, (6) grotesque movements of the tongue. The sudden appearance of such dramatic symptomatology should present little problem in diagnosis. Fortunately, treatment with antiparkinsonian drugs is usually equally dramatic, and rapid relief can be given to the sufferer.

A common symptom that usually precedes those noted above is psychomotor restlessness. This is described as a feeling of restlessness, jitters, and tremor that is often confused, by the patient, with the physical concomitant of anxiety. The usual reason for taking the tranquilizer is anxiety and the patient may well feel his condition is worsening. If the patient has previously had some relief from his symptoms by the drug, he would logically feel that increasing the dosage will decrease his restlessness. This, of course, compounds the symptomatology and the situation goes from bad to worse—often with the patient's family calling the physician to state that the patient has had a "stroke" or has gone completely psychotic.

In the past three months the writer has seen four cases in which this has occurred where prochlorperazine (Compazine) had been prescribed by the physician for moderate anxiety. Because this drug is usually quite effective in allaying anxiety, and because side effects in the usual dosage are so rare, the physician had not told the patient of their possible occurrence. Whether the physician should tell an already anxious patient that the medication he is to receive could produce complications (a negative suggestion) is a moot question. The writer, a psychiatrist, presents these four cases not in a spirit of criticism but merely as being instructive and of interest.

Case 1: A 23-year-old professional woman developed moderate anxiety following promotion to a position she felt unqualified to handle. Her physician had prescribed one tablet of 5 mg. prochlorperazine three times

a day. This had resulted in excellent relief of symptoms, and her physician subsequently prescribed the 15 mg. spansule so that she need take the medication only once a day. Increased job pressure produced some increase of anxiety. She then increased her ingestion to three 15 mg. spansules a day.

She was seen by the writer in consultation in the hospital where she had been brought by the Rescue Squad. At that time she was fully conscious but unable to articulate because of a protruding tongue, had markedly dystonic movements of her arms and legs and a marked generalized hyper-reflexia. Her case had been diagnosed as conversion hysteria. Dramatic relief was afforded by intravenous injection of 2 mg. benztropine mesylate (Cogentin Mesylate). Her relief from anxiety by prochlorperazine, however, had been so striking that this experience did not prevent her from reinstating the drug in the proper dosage subsequent to her discharge.

Case 2: A 43-year-old, semi-alcoholic factory worker developed severe anxiety following his wife's announcement of her seventh pregnancy. The patient's brother, a patient of the writer, was taking 10 mg. prochlorperazine three times a day, with good results. The patient compulsively began using his brother's medication, ingesting up to 60 mg. per day. When seen in the emergency room, his motor restlessness was so severe that he was diagnosed as having a severe anxiety state, and was hospitalized. Upon physical examination, the muscular rigidity and tremor prompted me to question him regarding medication. He readily admitted to what he had been taking. After 24 hours of hospitalization and 4 mg. of benztropine mesylate, he was ready for release. He is now seeing a psychiatric social worker.

Case 3: A 37-year-old seamstress developed insomnia and anxiety over her impending marriage. Her family physician had prescribed 5 mg. of prochlorperazine three times a day, which she subsequently increased on her own volition to 40 mg. per day. She was referred to the writer, since her anxiety appeared to be increasing. Only after the third psychotherapy hour did she admit to taking the referring physician's medication as well as another tranquilizer —promazine hydrochloride (Sparine), 25 mg. four times a day— prescribed by the writer. All medication was discontinued and her psychomotor restlessness decreased. Her anxiety is now being treated by psychotherapy. Interestingly enough this patient can differentiate between her current anxiety and previous psychomotor restlessness.

Case 4: A 9-year-old boy had syrup of prochlorperazine prescribed for acute diarrhea. Since the boy was prone to loose stools, the mother kept having the prescription refilled and dosed the boy according to her conception of medication. The mother brought the boy to me for increasing tremor of the hands and muscular rigidity. Discontinuance of medication brought relief of symptoms within the week.

Summary: Prochlorperazine (Compazine) is an excellent and widely used drug for the relief of anxiety. In the usual dosage form extrapyramidal manifestations are rare. When patients arbitrarily increase the dosage, they often produce symptoms that they diagnose as anxiety. A vicious cycle can occur wherein they feel they are becoming more anxious, and subsequently they increase the drug, compounding the symptomatology.

524 Main Street (53403).

COLON INTERPOSITION FOR ESOPHAGEAL BYPASS OR REPLACEMENT

Doctor John R. Pellett from the Department of Surgery, University of Wisconsin Medical School, read a paper at the February 1964 annual meeting of the Central Surgical Association at Rochester, Minn. It was published in the July 1964 issue of *Archives of Surgery.* The paper was "Colon Interposition for Esophageal Bypass or Replacement."

Doctor Pellett discussed 21 patients operated upon at the Wisconsin Medical Center using retrosternal colon interposition to replace the esophagus. Of these, 15 had malignant disease and 6 had benign lesions. Five major complications and 3 hospital deaths occurred in the group with malignancies and survival ranged from 3 to 36 months. No deaths and only one complication occurred in the six benign cases.

The author concluded that for malignancy of the esophagus, bypass should be done first. If no extrathoracic metastases are present, total esophagectomy as a curative procedure was recommended to be performed later.

The best results are to be anticipated with benign conditions. Doctor Pellett said that children with esophageal atresia and esophagostomy should eat and drink as a normal child while awaiting reconstruction.—V. S. Falk, M.D., Edgerton, Wis.

CLINICOPATHOLOGIC CONFERENCE

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Guest Editor: ROGER A. COTE, M.D.
Wood, Wisconsin

Case Presentation.* *Dr. Anthony J. Truszkowski:* The patient, a 72-year-old, married, retired businessman, was transferred to the medical service from an out-of-state clinic in October 1962. A left craniotomy had been performed four weeks earlier, with excision of a cherry-sized anaplastic carcinoma. Prior to surgery the patient had developed right hemiparesis following a Jacksonian seizure. Pneumonia and urinary retention occurred postoperatively.

Chest x-ray films dating back to 1945 revealed a slowly enlarging left upper lung mass. Thoracotomy was refused.

The patient's father had died of heart disease at the age of 71, and one sister died of a malignancy. The patient had a history of duodenal ulcer dating back to 1918, and a long history of cigaret smoking. In 1929 he underwent a subtotal gastric resection for gastrointestinal hemorrhage. In 1953 a left interscapular lipoma was excised. Adenocarcinoma of the prostate led to a radical perineal prostatectomy in 1955.

Physical examination revealed an elderly, cachectic, white man who had expressive aphasia, was confused and disoriented. A craniotomy scar on the left side was healing. The anteroposterior chest diameter was slightly increased. Atelectatic bilateral basilar rales were audible. A pleural friction rub was heard over the right lower lateral chest wall. Cardiac examination revealed only distant heart tones. The blood pressure was normal. Abdominal examination was unremarkable. Rectal examination revealed no prostatic mass. There was marked weakness of the right upper extremity and flaccid paralysis of the right lower extremity. A soft, nontender, circumscribed, subcutaneous mass measuring 8 by 15 cm. was palpable on the anterolateral left thigh. Neurologic examination revealed bilateral hyperreflexia, bilateral Babinski's signs and a Hoffmann's sign on the right side. Gross sensory examination was normal.

Laboratory findings were as follows: hemoglobin level, 8.9 Gm. per 100 ml.; hematocrit reading, 31%; white blood cell count, 9,300 per cu. mm., with 68 segmented cells, 9 band forms, 21 lymphocytes, and 2 eosinophils; sedimentation rate, 112. Urinalysis and the tests for syphilis (VDRL), blood urea nitrogen, serum electrolytes, calcium,

Fig. 1—This chest x-ray film, taken Jan. 17, 1946, shows a small mass in left upper outer quadrant.

phosphorus, serum bilirubin, zinc sulfate turbidity, BSP, acid phosphatase, and L-tartrate phosphatase were normal. Serum proteins were 6.1 Gm., albumin 2.4 Gm. per 100 ml.; and alkaline phosphatase, 15 Bodansky units. Stools showed 0 to 2+ occult blood. Sputum culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and tetracycline. Urine culture showed Pseudomonas aeruginosa. Electrocardiographic studies revealed left axis deviation and QRS pattern consistent with chronic lung disease.

* From Veterans Administration Center.

Fig. 2—This chest x-ray film was taken Oct. 16, 1962, 16 years following the first appearance of the left upper pleural cavity mass. The lesion has enlarged but still shows small contours without any calcification.

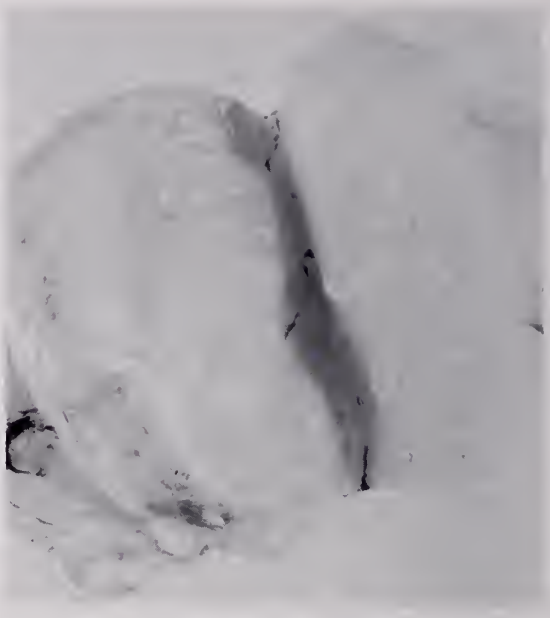

Fig. 3—A tumor mass from left upper pleural cavity with a wet, glistening surface. The gross impression was that of a myxoma. The mass revealed a gray-white surface and inner tumor nodules.

The patient was initially treated for staphylococcal pneumonia. He developed fever on the third hospital day. After he was given two blood transfusions, his strength increased, and aphasia and confusion diminished. A low-grade fever persisted and did not respond to a two-week course of colistimethate sodium (Colymycin). Multiple, hard, rapidly-growing, subcutaneous tumors developed on the trunk, face, and extremities. Biopsy was refused. Progressive weakness ensued along with increasing anemia and lethargy. There was evidence of bilateral pleural effusion. The patient died on Dec. 30, 1962.

Clinical Discussion. *Dr. Francis B. Landis:* The history and findings in this elderly man suggest two entities: a circumscribed, slowly-growing lesion in the left chest, present for years, and a terminal illness presumably due to a malignant tumor with widespread metastases.

I will discuss his illness in reverse order, considering the terminal disease first. When hospitalized in the spring of 1962, his complaints were anxiety and vague dizzy spells. There could be multiple etiologic factors for this: situational anxiety state, cerebral arteriosclerosis, and the cranial neoplasm, possibly already present. The anaplastic tumor resected from the left cerebral hemisphere was obviously metastatic in view of the patient's subsequent course. He steadily deteriorated, terminally developing multiple firm nodular densities in the subcutaneous tissues. These were most probably metastatic lesions.

The chest roentgenograms, in the later stage of his illness, show infiltration in the right lung and nodular densities at the periphery of the lung fields. The latter lesions simulate metastatic lesions to the pleura. The infiltration in the right lung apparently represented a pneumonia, presumably staphylococcal, responding to antibiotic therapy. However, the lesion in the right upper lung field did not clear completely, raising the question of bronchogenic carcinoma.

The long history of cigaret smoking and the metastatic cerebral lesion certainly suggest this possibility. It is well documented that squamous cell bronchogenic carcinoma occurs frequently in heavy smokers. Statistical reports indicate that the heavy cigaret smoker has about one chance in 10 of developing lung cancer; a nonsmoker, one chance in 270.

Bronchogenic carcinoma may metastasize to any organ, but the most frequent sites of

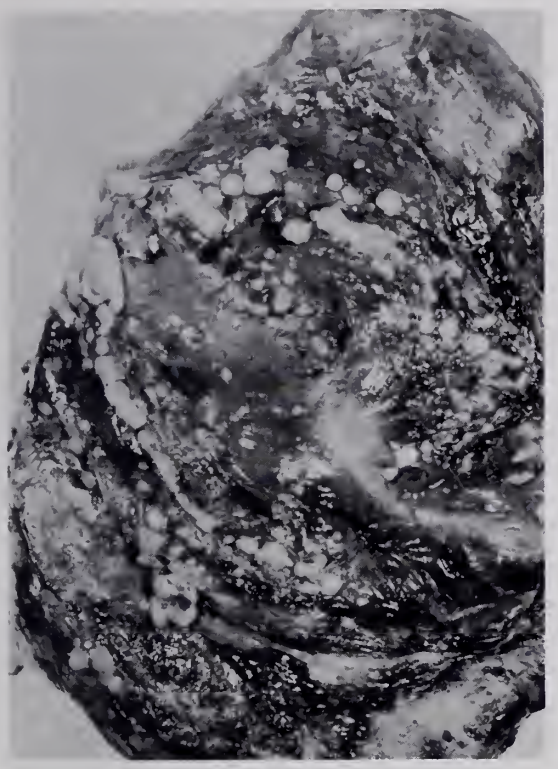

Fig. 4—Lung showing numerous nodules of metastatic hypernephroma.

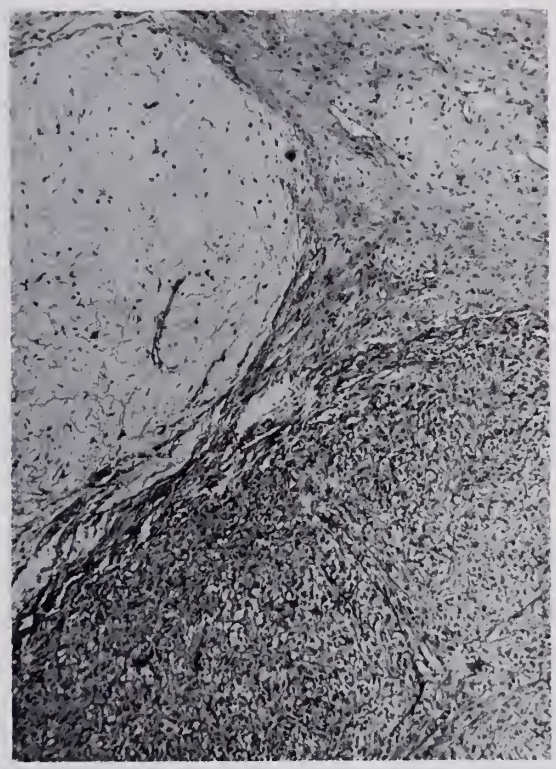

Fig. 5—Metastatic hypernephroma can be seen at the bottom, and at the top left there is a myxomatous-appearing lipoma.

distant metastases are liver, bone, central nervous system, and adrenal gland. Clubbing of the fingers occurs in about 10 per cent of patients. Arthritic symptoms have been reported, and may antedate other evidence of the tumor. Cases of Cushing-like syndrome are reported with anaplastic bronchogenic carcinoma, the tumor tissue secreting an ACTH-like substance. This patient did not develop any of these features. Nevertheless, bronchogenic carcinoma must be given serious consideration.

Other tumors come to mind, for example hypernephroma. This relatively common tumor is not infrequently overlooked, often manifesting metastases before the primary is suspected. It may metastasize widely. Metastases via the renal veins and inferior vena cava are typical. Golf ball metastases to the lungs are often seen and multiple metastases to subcutaneous tissues may occur. It is reported to be the most common metastatic tumor to involve the bronchus.

It is unlikely that the prostatic adenocarcinoma resected seven years before was responsible for the patient's picture of metastatic malignancy. Acid phosphatase was normal, and there were no osteoblastic lesions in the skeletal system. Cerebral metastases are infrequent secondary to prostatic malignancy.

In summary, I believe a malignant tumor caused death, but to pinpoint the primary site is not possible. Because of the patient's cachectic state, diagnostic x-ray studies of the gastrointestinal and urinary tract could not be carried out.

Now let us focus our attention on the slow-growing lesion in the left thorax. On review of serial roentgenograms it is apparent that this lesion was about 2.5 cm. in diameter, sharply circumscribed, oval in shape, and of homogeneous density when first detected in 1945. It is located posterolateral in the upper thorax and it is in contiguity with the pleura. This lesion does not have the cocoon configuration of an extrapleural neoplasm. Is it a filled cyst or a neoplasm? The lobular shape favors a tumor rather than a cyst. Lipomas and hamartomas present as lobulated tumors. About 50 per cent of hamartomas will show evidence of calcification.

Lipomas may present a peripheral radiolucent halo known as Heuer's sign. This lesion does not reveal Heuer's sign. It is of interest to observe the manner in which this lesion grew. The enlargement was not progressive or relentless; rather it grew at irregular intervals with periods of apparent stability. Review of unusual lung tumors shows that myxomas, lipomas, and hamartomas may grow in this manner.

We recognize that malignant tumors may remain quiescent for months and sometimes for years. However, for a malignant lung tumor to grow to this size and still remain sharply circumscribed, not erode ribs, cause pain, and not produce pleural effusion would be most unusual. Solitary malignant nodules frequently show dendritic processes peripherally, and usually do not retain a sharp margin. Again, with the extent of growth manifested, hilar node enlargement would be anticipated.

One may ask whether the tumor arose in the lung or from the chest wall. A review of the x-ray films does not answer this question. Certain diagnostic tests may help in differentiating; for example, diagnostic pneumothorax. If the lesion arises from the chest wall, the collapsed lung will separate away from the lesion. Needle biopsy of peripheral tumor masses has also been accomplished, aspirating tissue for microscopic study. However, such attempts are dangerous and may lead to serious complications such as pneumothorax, empyema, bronchopleural fistula, and bleeding.

Could this circumscribed expanding lesion represent a filled cyst, bulla, or cavity? I believe not. It would be extremely unlikely for a cyst to remain completely filled over such a prolonged period without evidence of secondary infection, or periodic discharge of contents, air-fluid level, and the like. Bronchogenic, or enterogastric, cysts may arise in the posterior chest; but they are usually found in the mid or posterior mediastinum, and usually close to the hilum.

Another possibility is a neurogenic tumor such as neurofibroma. Characteristically these tumors arise in the posterior chest, usually in the posterior mediastinum. However, they may also arise in the posterior thorax along a rib, originating from the intercostal nerve sheath. A neurogenic tumor presents a more dense appearance on x-ray film, and if grown to large size, usually causes symptoms such as pleural pain, or produces rib erosion.

Could the lesion in the posterior thorax represent a benign tumor which underwent malignant degeneration and metastasized widely? This is possible of course: such tumors are fibrosarcoma, rhabdomyosarcoma, and liposarcoma. However, if this occurred, we would anticipate that the tumor would lose its sharp peripheral margin and involve the chest wall or cause effusion. This did not occur. The tumor retained its lobulated, sharply-circumscribed appearance throughout, although enlarging.

To summarize, I believe that we are dealing with two separate entities. One is a malignant tumor, primary site probably being the lung or kidney, metastasizing widely to the brain, skin, lungs, and causing death. The excised cerebral metastasis most probably originated from this primary tumor. The other I believe was a benign lesion in the left posterior chest which grew intermittently to attain a large size. I do not believe this lesion was malignant. Rather I suspect a lipoma, fibroma, or hamartoma. Let me stress in closing that I would recommend such a lesion be removed early. When first detected one could not differentiate this circumscribed lesion from a carcinoma. The mortality from thoracotomy is less than one per cent. The chance of a solitary pulmonary nodule being malignant in an adult male varies in reported series from 15 to 50 per cent. Dr. John Steele reporting a group of 899 resected solitary nodules (VA, Armed Forces) noted: granulomas 53 per cent, malignant tumors 36 per cent, hamartomas 7 per cent, miscellaneous 3 per cent, pleural or chest wall 1 per cent. The axiom "lesion in doubt, should come out," still holds true.

Pathologic Discussion: *Dr. Roger A. Cote:* At autopsy the body was that of a cachectic and emaciated white man weighing no more than 90 pounds. The entire body revealed subcutaneous nodules over which the skin was freely movable. Some of these nodules appeared to be in the subcutaneous tissues, while others were attached to underlying skeletal muscle. They varied in size from 0.5 cm. to 2.5 cm. in greatest diameter. The ribs, anteriorly, were easily visible and some of them showed protruding firm nodules.

Many of the nodules were found to be free in the subcutaneous loose connective tissue while others were inside skeletal muscle. The

nodules in the ribs had destroyed the bone and could easily be cut with the scalpel. Upon sectioning, all of these nodules showed firm, gray-white, tumor tissue. The peritoneal cavity revealed all organs in their usual anatomical position except for an old, well-healed functioning gastrojejunostomy. Over the entire gastrointestinal tract there were small, firm, gray-white, tumor nodules implanted on the serosal surfaces, none of which measured more than 0.5 cm. in greatest diameter.

The thoracic cage revealed many of these small, gray-white to yellowish-white, tumor nodules in ribs and almost completely covering both pleural cavities. The under surface of the sternum revealed many more along the internal mammary vessels. Each pleural cavity contained 250 ml. of blood-tinged fluid. Each cavity also revealed numerous recent fibrinous adhesions extending from the lung to the lateral walls in cobweb fashion. In the superior portion of the posterior left pleural cavity there was a large myxomatous mass of yellowish-white tissue which measured 7 to 8 cm. in greatest diameter. This large mass was easily shelled off the thoracic wall and appeared covered with pleura. Sectioning of this mass revealed a wet, grayish-yellow, myxomatous surface with occasional firm gray-white nodules. Many of these nodules, such as those previously described, were adherent to the free surface of this myxomatous mass.

Both lungs were studded with grayish-white to grayish-yellow well-circumscribed nodules of tumor tissue. The right lung showed the usual three lobes and weighed 400 Gm., while the left lung had the usual two lobes and also weighed 400 Gm. Both lungs were collapsed except for some bilateral apical emphysematous bullae. The heart was present in its usual anatomical position, showed some brown atrophy, and weighed only 250 Gm. The chambers were essentially normal; however, sectioning of the mycardium revealed numerous small gray-white tumor nodules.

The pancreas, spleen, gallbladder, and extrahepatic biliary tree were normal. The nodes in the porta hepatis area were filled with gray-white tumor nodules. The liver weighed 1300 Gm. The capsule was smooth, glistening, and reddish-brown. Cut sections did show numerous grayish-white to grayish-yellow nodules of tumor tissue not exceeding 2 cm. in greatest diameter. The remaining gastrointestinal tract was essentially normal except for multiple small serosal tumor implants.

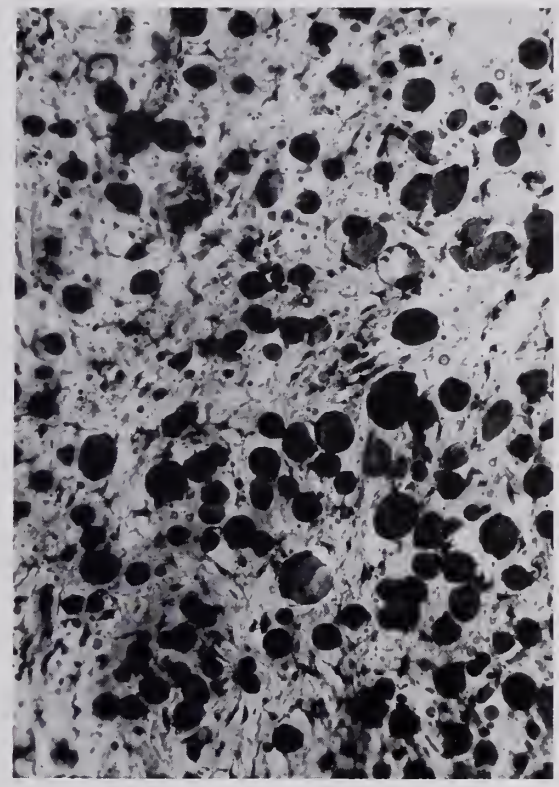

Fig. 6—This pleural tumor shows that in spite of the myxomatous appearance of the tumor it is really a lipoma. All dark globules represent Sudan positive fat.

The right adrenal gland was a somewhat globular mass weighing 150 Gm. There was no remaining recognizable adrenal tissue, and the gland had been completely replaced by grayish-yellow tumor with some areas of central necrosis. The left adrenal gland weighed 25 Gm. and showed numerous intramedullary and cortical nodules of tumor. The right kidney upon bisection revealed complete replacement of the upper pole by a large mass of yellow to yellowish-gray tissue with some central granular areas of degeneration. This mass measured at least 5 cm. in greatest diameter. The right kidney with the tumor mass weighed 225 Gm. The left kidney weighed only 100 Gm. and cut sections revealed occasional small irregular and poorly delineated grayish-yellow masses of tumor tissue, none of which exceeded 0.5 cm. in greatest diameter.

The pelvis of each kidney was essentially normal and both ureters were patent to the bladder. The urinary bladder, seminal vesicles, and testes, were essentially normal. The

prostate gland had been surgically removed and all that remained was a small mass of dense fibrous scar tissue.

Examination of the brain revealed signs of previous surgery in the left parietal region. A defect was present here which was surrounded by a small rim of degenerate brain tissue. The brain weighed 1300 Gm. and numerous sections at intervals of 1.0 cm. failed to reveal any tumor nodules.

The microscopic examination of the tumor in the upper pole of the right kidney revealed various patterns all of which were consistent with a hypernephroma. In some of the more rapidly growing areas, clear cells were almost completely absent and the cells grew in spindle fashion giving a sarcomatous appearance. The nodule, surgically removed from the left cerebrum approximately three months prior to death and which was described as an anaplastic carcinoma, was consistent with the pattern seen in the primary hypernephroma. All the metastases showed patterns consistent with hypernephroma. There were no signs of residual adenocarcinoma of the prostate gland and none of the metastases showed a pattern consistent with prostatic origin.

The mass seen on x-ray film in the left upper lung field and present for 12 years finally did reveal some increase in size and this was probably due to metastatic hypernephroma into the mass itself and by studding with tumor nodules of its pleural surface. Although this mass was first considered a myxoma because of its gross appearance, numerous microscopic sections with special stains such as the periodic acid-Schiff hematoxylin and the Sudan III revealed that this was actually a lipoma undergoing myxomatous degeneration.

The pathologic diagnoses would be hypernephroma of upper pole right kidney with dissemination to other kidney, both adrenal glands, all abdominal nodes, liver, diaphragm, pleural cavities, both lungs, heart, skeletal muscle, subcutaneous tissues, brain, and to a large lipoma of the posterior left upper pleural cavity.

DRUG WARNINGS

Thiazides in Pregnancy. Recent reports suggest that thiazide therapy during pregnancy may be responsible for thrombocytopenia in the newborn. In the study reported, the mothers of 7 thrombocytopenic infants had been given chlorothiazide, hydrochlorothiazide, and/or methyclothiazide for periods ranging from three days to three months during pregnancy. The problem is complicated clinically by the absence of platelet deficiency and antiplatelet antibodies in the mothers. Other studies have demonstrated the toxic influence of the thiazide derivatives on platelets as well as their precursors and their etiological relationship to neutropenia and agranulocytosis.

Following publication of reports of adverse effects on the newborn, the manufacturer of two of the diuretics in question contacted the FDA. The company has agreed to furnish "all available data" and the FDA has agreed to "work cooperatively with the manufacturer." Chlorothiazide (Diuril) and hydrochlorothiazide (Hydro-Diuril) are manufactured by Merck and Co.; methyclothiazide (Enduron) is an Abbott product. Both firms point to the excellent low toxicity reputation earned by the thiazide diuretics since their introduction six years ago, and to the reduced mortality from the toxemias of pregnancy during the same period.

The need for more and better controlled studies is apparent. Meanwhile, the prudent clinician will prescribe cautiously and in minimum effective quantity during pregnancy only those products which are clearly indicated.—Reprinted from *International Medical Digest*, July 1964.

IMMUNOLOGICAL CONCEPTS

A new review of current immunological concepts, practices and products written by Drs. Philip Catalfomo and Leo A. Sciuchetti of Oregon State University College of Pharmacy is available for physicians, nurses, and pharmacists concerned with epidemiology, immunology and public health.

This synthesis of authoritative data from many selected sources is produced by the publishers of the PHARMINDEX system of pharmaceutical reference. The text is combined with fast-referral tables and the bibliography contains over 70 references. Single copies of the review are available at 75 cents each from Skyline Publishers, Inc., P.O. Box 1029, Portland, Ore. 97207. Quantity prices are available.

THE U.S. DRUG INDUSTRY leads the world in development of new medicines: There have been 585 major new drugs made available since 1941 in the United States . . . nearly two-thirds of these originated in the U.S.

NEW DRUGS HAVE HELPED to sharply curtail death rates: The death rate per 100,000 population from tuberculosis fell from 45.9 in 1940 to 5.1 in 1962; whooping cough, 2.2 to 0.1; diphtheria, 1.1 to practical nonexistence.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
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Metronidazole (Flagyl) in Trichomonas Vaginalis Infections

By THOMAS C. SMITH, Ph.D., M.D., Milwaukee, Wisconsin

■ METRONIDAZOLE (Flagyl) (Fig. 1) is the first orally effective drug available for treatment of trichomoniasis in the human. Although only recently marketed in this country, it had been developed several years ago in France as the most promising of a group of nitroimidazoles. Extensive trials both abroad and in this country have established that the compound possesses a high order of selectivity against Trichomonas vaginalis in clinical use. In animals, it has low toxicity and has practically no pharmacologic effects. Adverse effects in humans have been mild and infrequent. No teratogenicity has been observed in either animals or humans. Before discussing further the details of treatment, brief mention of the occurrence and diagnosis of trichomoniasis is appropriate.

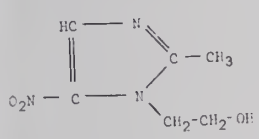

Fig. 1—Metranidazole (1-[2-hydraxyethyl]-2-methyl-5-nitraimidazale).

Incidence of Trichomonas vaginalis and its diagnosis. Infestation with this flagellate protozoan occurs in about 15 to 30 per cent of women[1,2,3] and 5 to 15 per cent of men[3,4,5] of reproductive age, the exact incidence dependent in part upon the thoroughness of diagnostic procedures. Of those affected, a variable number will have symptoms attributable to the organism, most often leukorrhea in women and urethritis in men. Significantly more positive diagnoses can be obtained by culture of the sample in a suitable medium than by microscopic examination of a wet smear, even when both are applied with equal expertness.[2,3,6] It is possible that the cervical glands, Bartholin's glands, and Skene's ducts harbor Trichomonas in women, and contribute to recurrence in inadequately treated cases, but this has not been clearly demonstrated.[7,8,9] In men, the organism apparently preferentially inhabits the prostate, explaining why the fluid obtained after prostatic massage is a much more reliable source for detection than either randomly voided urine or semen specimens.[4,5]

Transmission is believed to occur primarily by sexual contact. Cases in the prepuberal or sexually continent individual are curiosities,[10] while in those with poor hygienic habits as well as in the sexually promiscuous they are correspondingly common.[3,11] However, although epidemiologically sound, to describe trichomoniasis to patients as a venereal disease is unwarranted, for the alarm generated is not in keeping with our knowledge of the infestation as pathologically benign, albeit often symptomatically annoying. This does not deny that one may occasionally have to explain how transmission occurs in order to obtain the cooperation of both consorts in a successful treatment program.

Treatment of men and nonpregnant women. The oral dosage recommended by the Council on Drugs of the American Medical Association[12] is 750 mg. daily for 10 days. Treatment for only 3 days, however, has proven equally

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effective.[8,13] Tablets of 250 mg. are given 3 times a day. Topical therapy with 500 mg. tablets is also available, but there is no advantage in adding local to systemic treatment.[13] Since treatment locally is somewhat less effective than orally, this route should be reserved for the occasional patient who manifests gastrointestinal intolerance.

Using this dosage, several investigators have noted symptomatic improvement within a few days and complete disappearance of trichomonads in 90 per cent or more of their female patients.[1,6,7,8,9,11] A large proportion of male consorts of affected women also have been found to be infested, but their simultaneous treatment has not been convincingly shown to improve this initial success.[2,6,13,14] Cases in which trichomoniasis in the woman has not cleared or has recurred after an initial course of therapy usually respond well to a second course given to both spouses. Even though statistically more husbands of affected women are also affected than in the general population,[4] good practice dictates that in the man as well as in the woman, treatment not be undertaken without adequate history and physical examination. In the event that symptoms persist in spite of adequate treatment, other etiologies must be reconsidered.

After such oral dosage, the drug is rapidly absorbed and appreciable amounts are detected in the maternal serum and urine,[3,16] milk[16] and newborn blood and urine,[17] much of it apparently unchanged and microbiologically active. Presumably, the drug also finds its way into the tissues and secretions of the genitourinary tract where it exerts its parasiticidal action. Nonetheless, details of its fate and mode of action have still to be elucidated.

Lack of effect on other organisms found in the female gentiourinary tract, such as Candida albicans, the Döderlein bacillus, and other bacteria argue for its specificity and suggest that the drop in pH in the vagina[2,18] does not in itself eliminate the trichomonads. The development of parasite resistance to the drug has not been shown, and cannot explain those occasional instances in which the trichomonads persist. Rather, reinoculation from outside, as mentioned, or occasionally, the patient's failure to adhere to the prescribed regimen are most likely to blame. Certainly, metronidazole is overwhelmingly superior in efficacy to previously available compounds,[3,6] making the occasional failure relatively insignificant.

Treatment of the pregnant female. Treatment of trichomoniasis in the pregnant patient involves several peculiar problems. For reasons that are not clear, it has tended to be more frequent, more symptomatic, and more resistant to treatment in these women.[3,17,19] Furthermore, there has been understandable concern that many newer drugs might have adverse effects on the outcome of the pregnancy. Several reports, however, show that there is no increase in the frequency of prematurity or of the complications of pregnancy in patients receiving metronidazole. Also, the incidence of fetal malformations has not been influenced even when the drug was given during the first trimester, which spans the period of organogenesis in the embryo.

The physician will regard a woman who has missed a period as possibly pregnant and will withhold any but the necessary medications pending confirmation, for it is during this critical period of embryogenesis that a potentially teratogenic drug could exert its effects. Nevertheless, many women will receive drugs during this period without the physician's or patient's foreknowledge. Therefore, in this situation rather than when pregnancy is established is when adverse effects on fetal development are most likely, and where the physician's diligence in noting and reporting a suspicious coincidence of inadvertent drug administration and subsequent fetal malformation is most important. In the light of present evidence, then, there is no reason why metronidazole should not be given to the pregnant patient after this critical period has elapsed, especially when symptoms of vaginitis are particularly distressing. Trichomoniasis responds to the drug as dramatically as in the nonpregnant patient, and there is no increase in the frequency or severity of side effects.[2,7,13,14,18,19,20,21]

Complications of treatment. In addition to occasional recurrence of the infestation, frequent overgrowth of Candida albicans during or following metronidazole therapy has been noted by several observers.[1,7,14,18,21] Failures may be seen also when mixed infections with the yeast and flagellate were initially present, but not recognized. In either event, moniliasis responds to specific antifungal therapy, such as gentian violet or nystatin, applied locally.

Adverse effects. Gastrointestinal symptoms occur in about 10 per cent of patients. Nausea or an unpleasant taste is the most frequent complaint, while diarrhea, vomiting, or anorexia are less common. Rarely are symptoms severe enough to warrant discontinuation of the medication and no objective signs of gastrointestinal or liver disturbance have been reported.[2,6,15,21,22] Milk or antacid administration may be helpful in controlling symptoms in some cases.

A variety of nervous symptoms also have been encountered in a few individuals, most commonly manifested as dizziness, headache, nervousness, or insomnia. Since in dogs given very high prolonged doses of the drug, neurologic signs occurred which were reversible on suspending administration, there has been an awareness that similar changes might occur in man. An isolated case of amblyopia[22] and one of vertigo[21] have been reported in patients receiving metronidazole, but disappeared soon after treatment was completed and may have been coincidental. No neurologic syndromes have been encountered, even with repeated administration.

Dermatologic symptoms of pruritus, urticaria, or other rashes have been noted in one per cent or less of patients, and may represent an idiosyncratic response.[2,15,23-26]

It is pertinent to note that in one well controlled study, patients receiving placebo reported significantly more dizziness and headache than those receiving metronidazole. Gastrointestinal and dermatologic symptoms were also seen with placebo, albeit with less frequency than with the drug.[27] Such studies remind us of the difficulties in evaluating symptoms associated with any treatment, and warn against attaching undue significance to such symptoms without proper control observations.

Most investigators have not found hematologic changes in patients receiving therapeutic doses of metronidazole, but a few groups have reported transient changes in some of their patients.[2,15,21] These most often appeared as leukopenia, or, in a few instances, as leukocytosis or anemia. In none were there any serious sequellae, and in all the blood picture returned spontaneously to normal. Nonetheless, one should keep in mind the possibility that untoward reactions of the hematopoietic system to this drug may occur.

Finally, the inherently low toxicity of the drug should be emphasized. This has been demonstrated by one case[24] in which a patient reportedly took about 20 Gm. with suicidal intent, apparently without adverse effects. Assuming all the drug was absorbed, this would amount to at least 20 times the therapeutic dose. This is far below the dose per kg. which elicits toxicity in animals.

Contraindications and precautions. In view of the occasional cases in which hematologic reactions have occurred, the Council on Drugs[12] has recommended that metronidazole not be given to patients with blood dyscrasias, and advises that blood counts be obtained, especially on patients receiving more than one course of treatment. They have also warned against its use in patients with central nervous system disease, based on the observation of neurologic changes in dogs, and suggest the drug be stopped if neurologic symptoms or signs develop. They also doubt the wisdom of giving the drug during the first trimester of pregnancy.

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DIAGNOSIS OF PANCREATIC DISEASE BY PHOTOSCANNING

HAYNIE, THOMAS P., SVOBODA, ALBERT C. AND ZUIDEMA, GEORGE D., Departments of Internal Medicine and Surgery and the Nuclear Medicine Unit, University of Michigan Medical Center, Ann Arbor, Mich.: *Journal of Nuclear Medicine*, 5:90 (Feb.) 1964.

It has been shown that if selenium-75 is substituted for sulfur in methionine, about 6 per cent of a dose of this compound could be demonstrated in the pancreas two hours after administration. This is about eight to nine times the concentration found in the liver.

Thirty-seven patients with presumed pancreatic disease were given this compound and the results are reported. Patients were given two glasses of milk and then nothing by mouth until after the test. Two hours later, 100 U. of pancreozymin in 20 ml. of saline was administered intravenously over three to four minutes. SE^{75} selenomethionine was given intravenously in a dose of 3 μc./Kg./body weight. Scanning was started 30 minutes later.

The pancreas was well visualized in 12 of 15 normal patients In 8 of 11 with pancreatitis and 7 of 11 with carcinoma, abnormalities consisting of a diffuse decrease in concentration or local reduction in uptake were observed. The procedure proved useful in these conditions and also in excluding pancreatic abnormalities in others. Certain difficulties encountered were brought about by variations in the normal pancreas or by interference from radioactivity in the liver.—Reprinted from *International Medical Digest*, July 1964.

REGIONAL PULMONARY BLOOD FLOW IN MAN BY RADIOISOTOPE SCANNING

WAGNER, HENRY N., JR., SABISTON, DAVID C., JR., HO, MASAHIRO, MCAFEE, JOHN G., MEYER, JON K. AND LANGAN, JAMES K.: *Journal of the American Medical Association*, 187:601 (Feb. 22) 1964.

Provided the substance is completely cleared and not metabolized during the period of observation, the rate of accumulation in any region of the body is proportional to the blood flow to the region.

Macro-aggregated albumin was labeled with radioactive chromium isotope and acidified to a pH of 5.5 The material was then oscillated for 20 minutes in a water bath at 75 C. Only 0.5 cc. of a 1 per cent solution (300 to 1,000 microcuries) of the resultant suspension, after testing to insure freedom from contamination, was injected intravenously immediately prior to scanning.

Artificial pulmonary emboli were produced in dogs by passing latex balloons filled with radiopaque material into the inferior vena cava or into the external jugular vein. In 43 dogs it was possible to determine which lobar artery was involved without the person performing the scan having any prior knowledge. Further scanning after surgical removal of the embolus was also performed.

The isotope labeled macro-aggregated albumin accumulated immediately in the lungs, permitting localization by radioisotope scanning techniques. Rapid degradation of the aggregates occurred shortly after administration. The subsequent clearing of the lungs and excretion of the radioactivity in the urine resulted in radiation doses well within the permissible range. No untoward effects were observed in man, rat, or dog. Regional circulatory defects were observed in 70 patients with lung tumors, cysts, pneumonia, and atelectasis. The lung scans have also been carried out in 13 patients with massive pulmonary embolus with localization in each case. This technique can be used to study regional circulation in the systemic as well as the pulmonary circulation.—Reprinted from *International Medical Digest*, July 1964.

ACP BOOKLET AVAILABLE

Copies of the booklet, "Your Physician Looks at . . . Family Health," are available in limited quantities from the ACP headquarters office, according to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104. Fourth in a series prepared by the ACP as part of its public information program, the booklet is based on material presented at a community forum held in Atlantic City in conjunction with the ACP's 45th annual session.

SPECIAL REPORT

National Conference on Institutionally Acquired Infections

By BURTON A. WAISBREN, M.D.

Milwaukee, Wisconsin

■ THE PURPOSE of this report on the National Conference on Institutionally Acquired Infections, which was held in Minneapolis under the auspices of the School of Public Health, University of Minnesota, and the United States Public Health Service on Sept. 4 through 6, 1963, is to present to the physicians in Wisconsin information that may be of help to them, either in control of infections in their own hospitals or in the planning of new institutions in their own communities. The author was asked to represent the Wisconsin State Medical Society at this conference. He will try to present the information in as objective a manner as possible and will save his own interpretations for a short paragraph at the end.

INTRODUCTION OF SUBJECT

EPIDEMIOLOGY—Dr. James L. Goddard, Chief, Communicable Disease Center, Atlanta, Georgia.

Important points of the presentation:

1. All hospital records to date have underestimated the problem of hospital infection.
2. As an example of a common error in technique he cited the barium meal enema procedure as one that, potentially, can spread infection and that should be done with resterilized equipment for each patient.
3. He cited the necessity for hospitals seeing to it that all their personnel were immunized against polio, tetanus, influenza, diphtheria, and smallpox.

LABORATORY—Dr. James G. Shaffer, Director of Microbiology and Hospital Epidemiology, Lutheran General Hospital, Park Ridge, Illinois.

1. Doctor Shaffer was not in favor of carrier studies because he felt that, when carriers were found, nothing could be done about it, anyway.
2. He emphasized surveillance of environment and also pointed out that air counts of numbers of Staphylococci did not correlate with hospital infections.
3. The most important correlation he emphasized was general cleanliness throughout the hospital.

ENVIRONMENTAL—Dr. Jack Haldemen, Assistant Surgeon General, Public Health Service, Washington, D.C.

As director of the Hill-Burton Program, Doctor Haldemen's remarks are of particular importance to people planning new installations.

Points of emphasis:

1. Open wards are a thing of the past.
2. Isolation areas are to receive more emphasis.
3. He felt that carriers were an important factor in Staphylococcal disease.
4. Damp mopping with bactericidal solutions is essential in hospital housekeeping.
5. Care must be taken in planning air conditioning systems, with zoning and humidification being of particular importance.

SYMPOSIUM ON THE BACTERIOLOGY OF THE HOSPITAL ENVIRONMENT

SURFACES, THEIR IMPORTANCE AND CONTROL—Dr. Carl Walter, Peter Bent Brigham Hospital, Boston, Massachusetts

Doctor Walter, a surgeon at Peter Bent, is a pioneer advocate of environmental control.

1. He found disseminating carriers, whom he called "shedders", in two out of forty of his House Staff by sampling the air in the rooms where they live.
2. They were unable to cure these carriers but allowed them to stay in the Operating Room and in nurseries, where they suggested they wear masks.
3. Treatment of floors can best be done by flooding with bactericidal solutions and drawing up the material with wet vacuums.
4. He emphasized that the air of the rest of the hospital should be just as free of bacteria as the air of the Operating Room.
5. All waste material throughout the hospital should be put in containers with liners, the liners to be stapled shut before removal of containers.

AIR, ITS IMPORTANCE AND CONTROL—Professor T. W. Kethley, Professor of Applied Biology, Georgia Institute of Technology, Atlanta, Georgia.

1. Professor Kethley is a sanitary engineer who made the point that while we have the equipment to do almost anything in regard to air conditioning hospitals, it has not been decided how best to use it.
2. In planning an Operating Room ideally there should be thirty complete changes of air per hour and this can be accomplished by multiple openings in the ceiling.

DESIGN FOR ISOLATION—Mr. Nils G. Brink, Arkitect Sar, Orebro, Sweden.

Mr. Brink, an architect from Sweden, presented a design for an isolation hospital that he built in Sweden. This presentation pointed out what may become the European solution to this problem, that of going back to isolation hospitals for all patients with infections that may be spread in institutions. Points of interest in his hospital were that there were no connecting ducts, recirculation of air, or visitor contact. There was also an ingenious bed sterilizing center.

STERILIZATION TECHNIQUES—Dr. J. C. Kelsey, Director, Disinfection Reference Laboratory, Central Public Health Laboratory, London, England.

1. Doctor Kelsey discussed sterilization and emphasized that "paper indicators" indicate only that something has been in the autoclave rather than that it is sterile.
2. He felt that each hospital should have a "sterile equipment supervisor" with responsibility for equipment and material sterilization.

HOUSEKEEPING—Mr. Minor Vandermade, Jr., Assistant Administrator, University of Michigan Hospital, Ann Arbor, Michigan.

This very dynamic, General Motors type of executive made these points:

1. Adequate hospital housekeeping should not raise the hospital budget. It is important to work "smarter, not harder." Five per cent of the hospital budget is the usual expenditure for housekeeping and for this the hospital should have a department that takes care in selecting personnel, giving them proper orientation, on the job training, proper motivation, and a knowledge that their activities are being closely supervised.
2. He felt that the hospital should not, and could not, test various chemicals for disinfecting ability but should rely on standard testing laboratory reports. In essence, good administration and "elbow grease" should provide a clean hospital without excess expense.

WASTE HANDLING—Professor G. S. Michaelsen, Associate Professor, Environmental Health, School of Public Health, University of Minnesota.

1. Vigorous bedmaking spreads bacteria throughout the room.
2. Linen chutes can be used only if a vent is placed in the top of them to provide exhaust ventilation and negative pressure. (Hospitals that wish to continue using laundry chutes should write to Professor Michaelsen for plans of his simple, inexpensive conversion unit.)
3. Exhaust fans should be placed in the dishwashing facilities area, over the dishwashing machines, scraping area, and garbage grinders.
4. All waste material should be put in heavy, water-proof paper liners.

LAUNDRY PRACTICES—Dr. Brooks D. Church, Department of Microbiology, University of Minnesota.

Points of emphasis:

1. Plastic laundry bags which dissolve in the washing machine were considered to be worthy of extensive trial.
2. A good vent over the initial sorting area in the laundry would reduce air contamination of outgoing laundry by bacteria released in air of the sorting area.

LABORATORY

ISOLATION AND IDENTIFICATION—Dr. John Ulrich, Department of Microbiology, Mayo Clinic, Rochester, Minnesota.

1. Doctor Ulrich felt that there was correlation between the numbers of coagulase positive Staphylococci in the air and in infection rates.
2. Shedders of Staphylococci found at the Mayo Clinic were not prohibited from the Operating Room and no effective way of treating them was found.
3. There was no correlation between nasal carriers and wound infection; the shedders of Staphylococci in large numbers were less than five per cent of the personnel.
4. He emphasized that phage typing was just an epidemiological tool and that many phage types will cause difficulty.

ANTIBIOTIC SENSITIVITY—Dr. James Greer, Department of Dermatology, Henry Ford Hospital, Detroit, Michigan.

Doctor Greer made the strong point that sensitivity studies were just one bit of evidence to be used in the treatment of patients.

Dr. J. C. Colbeck, Chief of Service Pathology, Shaughnessy Hospital, Vancouver, B. C., Canada, a longtime leader in the problem of hospital infections, stated during the discussion period that in his hospital it was the practice to wait for evidence of harm before carriers were searched for and treated.

EFFECT OF ENVIRONMENT ON VIRULENCE—Dr. Joseph J. McDade, Microbiologist, Communicable Disease Center, Savannah, Georgia.

Doctor McDade presented what was probably the only new bit of research shared at the Conference when, in a very well controlled study, he showed that Staphylococci suspended in air retained their virulence for mice for at least four days.

AIR SAMPLING TECHNIQUES—Mr. Lawrence B. Hall, Special Assistant for Planetary Quarantine, National Aeronautics and Space Administration, Washington, D.C.

Mr. Hall presented data regarding the various air samplers that are available and pointed out that it was well within the range of any large hospital laboratory to conduct air sampling studies in vital areas. He emphasized, as did many other members of the Conference, that simple settling plates were worthless.

SURFACE SAMPLING TECHNIQUES—Mr. Donald Vesley, Instructor, School of Public Health, University of Minnesota.

A paper by Mr. Vesley showed various methods of sampling surfaces but made the very impressive point that there is no evidence that a clean environment has any relationship to the infection rates found in various hospitals.

EPIDEMIOLOGY

VIRUSES—Dr. John D. Millar, Chief, Smallpox Investigation Unit, Communicable Disease Center, Atlanta, Georgia.

Doctor Millar discussed the recent smallpox outbreaks in England and the Scandinavian countries and pointed out that travellers with smallpox, admitted to hospitals in these countries, had given the disease to numerous hospital employees. His presentation made it obvious that each hospital in this country should see to it immediately that all of their personnel have smallpox vaccinations, since air travel makes importation of this disease increasingly possible.

STAPHYLOCOCCI—Dr. Robert I. Wise, Head, Department of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania.

1. In discussing the epidemiology of Staphylococcal infections, Doctor Wise felt that hand washing was one of the most important ways of preventing the spread of Staphylococcal disease.
2. He did not believe carriers were important but did feel that an Isolation Ward, similar to the one he has set up in his own hospital, was of value.

SURGICAL INFECTIONS—Dr. William A. Altemier, Professor of Surgery, Cincinnati General Hospital, Cincinnati, Ohio.

1. Doctor Altemier has been well known for many years as the proponent of "contact spread" rather than "environmental spread" of wound infections. He pointed out that the infection rate in 43 patients who had open heart resuscitation done without any sterile preparations was five per cent—the exact rate that is present in most large hospitals for surgery done under "ideal conditions."
2. His emphasis was on meticulous care to prevent contact spread from person to person and cited a .7 per cent infection rate on his Service as evidence for his thesis. (It was pointed out, however, by Doctor Walter, that meticulous care had been taken regarding environment of his Service, as well.)

URINARY TRACT—Dr. Jay P. Sanford, Department of Internal Medicine, University of Texas Southwestern Medical School, Dallas, Texas.

Doctor Sanford discussed the epidemiology of Gram-negative infections and indicted the catheter as the main source of difficulty. Intermittent catheterization is much to be preferred over an indwelling catheter. If an indwelling catheter is used, a three-way closed system with drip of an antimicrobial solution is to be employed.

SURVEILLANCE—Dr. Philip Brachman, Epidemiology Branch, Communicable Disease Center, Atlanta, Georgia.

1. Doctor Brachman, a graduate of the University of Wisconsin of whom we can all be proud, discussed surveillance and its importance. He presented many forms that could be used. Hospital Sepsis Committees should write to him directly for various forms available, since some form of direct surveillance of Staphylococcal infections was agreed by all to be a "must" in each hospital sepsis control program.
2. He emphasized that one person in each hospital should be in direct charge of surveillance, with title and well defined responsibilities.

SPECIAL CONTROLS

CONTROL THROUGH PATIENT ISOLATION—Dr. Ward Bullock, Department of Medicine, Yale University Medical Center, New Haven, Connecticut.

Doctor Bullock presented the details of the Isolation Unit at the University of Minnesota Hospital. This unit, which has been in operation for several years, has had excellent acceptance by the Staff and has not proven dangerous to its operating personnel. Its influence on the infection rate has not been determined, however, and it is, admittedly, a very expensive proposition.

CONTROL THROUGH EDUCATION—Dr. Ralph Adams, Surgeon-in-Chief, Huggins Hospital, Wolfeboro, New Hampshire.

Doctor Adams presented the program of education for control of infection of his hospital in New Hampshire. In essence, he felt that a "compulsive perfectionist" such as he termed himself, who emphasized meticulous cleanliness of the Operating Room area could, by example and imaginative teaching techniques, motivate an entire hospital staff to cleanliness. With this approach his hospital infection rate is under one per cent.

CONTROL THROUGH DESIGN—Mr. August Hoenack, Chief, Architectural and Engineering Branch, Public Health Service, Washington, D.C.

Mr. Hoenack, of the Hill-Burton Programs, discussed new trends in hospital design for control of infection.

1. In surgical suites there should be 100 per cent outside air used, twelve changes of air per hour, and positive pressure air conditioning. There should be separate rooms to change the patients from cart to Operating Room table.
2. In nurseries there should be a minimum of 250 cubic feet per baby.

SUMMARY

RESPONSIBILITIES OF GOVERNMENT AGENCIES—Dr. Albert E. Heustis, State Health Commissioner, Michigan Department of Health, Lansing, Michigan.

1. Doctor Heustis discussed the responsibility of the local and state governments. He felt that

the local Health Officer should become involved in problems of hospital sepsis.

2. He felt the state should provide specialists to investigate epidemics, engineering help, special studies as indicated, and advisory committees.

3. Federal responsibility should be strictly to assist the states with standards, guides, and money.

ASSISTANCE FROM HILL-BURTON PROGRAM—Mr. August Hoenack, Chief, Architectural and Engineering Branch, Public Health Service, Washington, D. C.

1. Mr. Hoenack described the Hill-Burton Program, details of which are somewhat outside the scope of this Conference, but which is involved in sepsis to the extent that approval of designs for new hospitals will be contingent on their including specifications designed to control infection.

2. The Engineering Division of the Hill-Burton Program can be of particular help in aiding communities design their hospitals correctly in this and other respects.

ASSISTANCE FROM COMMUNICABLE DISEASE CENTER—Dr. Alan W. Donaldson, Deputy Chief Communicable Disease Center, Public Health Service, Atlanta, Georgia.

The Communicable Disease Center's role in control is primarily that of helping the states when they are asked and in promoting conferences, such as the one of which this is a report, to dessiminate general knowledge.

COMMENT

My general comments and reflections regarding the Conference are as follows:

1. There continues to be a country-wide problem of hospital infection with between five to ten per cent of patients who undergo major surgery developing postoperative wound infection.

2. There have been no striking developments regarding control of these infections in the last five years.

3. There are two main "camps" of those who have studied this problem—those who advocate environmental control and those who feel that contact is the most important factor. It would seem to me that both factors are important.

4. There is no evidence that the control of either environment or contact will decrease the wound infection rate.

5. There is general agreement that attempts should be made to control environment.

6. No person in authority seems willing to suggest that anything be done about Staphylococcal carriers within hospitals. This attitude has developed since it has been well shown that carriers cannot be treated by any known means and it seems to be generally felt that it is impractical to remove them from any areas within the hospital.

7. On the basis of this Conference the following list might be presented as an accepted modern sepsis control program.

   a. Environmental control: each hospital must be kept meticulously clean. The methods already available, if properly applied, are adequate.

   b. The future will probably bring requirements for air sampling of vital areas in regard to bacterial counts. Standards regarding the amount of air contamination will be devised.

   c. Wet floor cleaning with wet vacuum cleaners will become generally used, sealable paper liners in all waste disposal units are necessary, venting of laundry chutes and of areas in the laundry and kitchens will be necessary.

   d. Need for extensive hand washing, regulation of traffic in the Operating Room, boots in the Operating Room, and banishment of anyone with open Staphylococcal infection, are generally accepted.

I was unable to find anyone at the Conference willing to come to grips with the problem of carriers. It is conceded that between one to five per cent of hospital personnel "shed" large numbers of coagulase positive Staphylococci at all times and that it is relatively easy to determine who these people are. There are no means yet available to prevent them from shedding organisms. Most people felt that it was not a good idea to determine who the carriers were unless something was going to be done about them when they were found. A court case was cited in this respect in which a hospital was held liable for a nursery infection, since they were aware of an 80–81 carrier within their nursery and had not removed her.

The cogent argument against hospitals involving themselves with carriers is that it has not been shown that the removal of carriers would decrease the infection rate. However, by the same token, cleaning environment has not been shown to decrease infection rate either, and there does not seem to be much objection on anyone's part to measures directed towards increasing cleanliness. It seems that it is easier to manipulate things than people. However, it remains my opinion that until it can be shown that Staphylococcal shedders are innocuous, that they should be searched for and denied access to the sensitive areas of the hospital, namely the Operating Room and Newborn Nurseries.

Finally, it is apparent there remain many unsolved problems regarding institutionally acquired infections in this country.

THE PRESIDENT'S PAGE . . .

W. P. CURRAN, M.D.
Antigo, Wisconsin

The Medical Politician

■ DURING THE MONTH of October, the second Interim Session of the House of Delegates of the State Medical Society was held at the Society headquarters in Madison. The activities of the Delegates and Alternates during these sessions have always been of great interest to me since becoming a member of the State Society.

My first contact with the so-called "medical politicians" was in 1935 when I attended my first state medical convention. Later, as an Alternate and then a Delegate to the House, I could not help but be impressed by the sincerity, interest, and devotion to duty by the members of the House of Delegates.

In a general way, a politician may be defined as one who is interested in public policy, who is judicious, prudent, and artful. To me, a so-called "medical politician" is one who is desirous of doing all he can to better the atmosphere in which he lives and works, and who is not afraid to bear the brunt of the many criticisms, just or unjust, which he may reap for his efforts in matters of vital interest to him, to all the physicians he represents, and to the public which he meets and cares for every day of the year. He is one who, when asked to make a trip to some part of the State to participate in a medical conference, will gladly take the time from his work—with no thought of financial recompense to himself, or to the discomfort this trip may cause to his home and family—and try to do the best he can in representing the hundreds of physicians who cannot, or will not, make a similar sacrifice.

I was amazed to learn that, during the year 1962, had all the men who took part in the many committee meetings, AMA conventions, and the State convention billed the State Medical Society for time, mileage, food, and the like, the total bill would have been roughly $17,410. The amount actually paid out by the Society was roughly $7,200. When one realizes what impact such expenditures—which have to be made up to a great extent by the dues structure—would have on the entire Society, a great vote of thanks is due these "politicians" from all of us.

May the "medical politicians" grow in number, prosper in all their endeavors, and live the long, fruitful lives they deserve. My thanks to them all.

the WISCONSIN MEDICAL JOURNAL
Published Monthly
OCTOBER 1964
Vol. 63 No. 10

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Doctor Welch Remembered

EDITOR'S NOTE: *Perhaps the last official act of a tragically brief term of office is the following invitation from the late Norman A. Welch, M.D. The greatest possible tribute to this great medical statesman would be record-breaking attendance at the next AMA clinical convention. Medical education was Doctor Welch's first love and the upcoming scientific program promises to be uniquely his.*

■ IN THE AMERICAN Medical Association's long history of fostering the continuing education of practicing physicians, the 18th clinical convention next November 29–December 2 in Miami Beach marks another milestone.

An excellent scientific program has been planned for the meeting. Particularly noteworthy is the postgraduate course on obstetrics, consisting of a comprehensive series of lectures by outstanding teachers.

Other sessions are devoted to timely subjects of wide interest and will be followed by question-and-answer or discussion periods. The fireside conferences and breakfast roundtables will provide further time for informal discussion.

There is today an acute awareness of the need for continuing education throughout the medical profession. Much effort is currently being exerted to provide better educational opportunities for practicing physicians. Yet, learning obviously remains an individual matter which rests on the personal initiative of each physician.

I urge every physician who possibly can to take advantage of the educational opportunity represented by the clinical convention.

—NORMAN A. WELCH, M.D., *President*
American Medical Association

The Mess in Blood

A FEDERAL TRADE Commissioner recently made a milestone ruling to the effect that human blood is a commodity in interstate traffic and therefore entitled to the same untrammeled distribution as sugar, detergents, automobiles, or any other product brought to the market place. An initial decision held that the Community Blood Bank of the Kansas City Area, Inc., the Kansas City Hospital Association, its members and 14 pathologists acted in restraint of trade by refusing to use the blood and plasma collected and offered by a local commercial blood bank.

The medical groups were cited by the Federal Trade Commission; the matter was examined by a Federal Trade Commission examiner, and the ruling will be reviewed by the full commission. If the initial decision is sustained by the commission, the defendants have recourse in the U. S. Court of Appeals.

The burden of complaint by the FTC seems to be that hospitals and pathologists in the Kansas City area had formed their own community, not-for-profit blood bank to avoid the need for purchase of blood from commercial banks. The consistent refusal of all institutions and pathologists to accept the blood sold by the commercial firm indicated a conspiracy in restraint of trade. For, according to the FTC examiner, "whole blood (human) is viable human tissue mixed with an anticoagulant in a sterile container which must be stored and refrigerated and the admixture is a commodity and/or article of commerce . . . and as such is subject to 'trade' and 'commerce' within the meaning of these terms as used in the FTC Act."

The hospitals and the pathologists claimed that blood was not a commodity within the meaning of the FTC Act, that non-profit or not-for-profit medical institutions could not enter into a conspiracy for the restraint of trade, and, most importantly, that it was immoral to sell human blood for a profit and that blood storage and utilization were medical services that should be under the control of medical institutions and medical personnel.

While rejecting the defense of the hospitals and the pathologists, the FTC examiner recognized the danger that could arise from an absolutely unrestricted trade in blood. He said the order was not intended to impinge upon the duties of individual physicians in the care of their patients, nor does it "prevent any physician, responsible for the care of any patient, from exercising his individual medical judgment to determine what whole blood (human) and from what source, if any, shall be utilized in the care of such patient." From this it would appear that the FTC examiner would allow the right of each individual physician to refuse the blood offered by a commercial blood bank, but if all the individual physicians refused, the common refusal would constitute conspiracy in restraint of trade.

Clearly, the crux of the matter is whether the human blood is a commodity within the meaning of the FTC Act. If it is and commercial blood banks are permitted to exist, the decision of the examiner is a valid one. If, on the other hand, as most medical personnel believe, the collection, storage, and utilization of human blood is a medical service, there is no room for commercial enterprise outside the supervision of responsible medical personnel acting as agents of responsible medical institutions.

The dangers inherent in free-enterprise purveyance of human blood are obvious. They are dangers that need not exist if the collection and distribution of blood is strictly controlled, and controlled it must be if the doctor is to have confidence in the source of the blood.

If a doubt as to the commercial characteristic of blood exists under present law, additional legislation is necessary to clarify its status. It is hoped that bills now being introduced in the House and Senate will accomplish this purpose. In the meantime, however, hospitals should examine the prices at which they sell blood to their patients. If the charges can be reduced to a level which would make competition unprofitable, no commercial blood bank would attempt to sell blood, and the danger of unrestrained traffic in blood would be eliminated.

The position of the Kansas City area hospitals and pathologists is strong. Hopefully, their argument will be upheld by higher judicial review. But their contention applies to hospitals as well as commercial blood banks. It *is* immoral to sell blood for a profit. The job of the hospitals is not to shut out commercial blood banks on principle, but to create circumstances of service and cost with which they can't compete. —D.N.G.

TRANSACTIONS OF HOUSE OF DELEGATES

EXTRAORDINARY SESSION • MAY 11, 1964 • MILWAUKEE

AN EXTRAORDINARY SESSION of the House of Delegates of the State Medical Society of Wisconsin convened on Monday, May 11, 1964 at 4 p.m., R. E. Callan, M.D., Speaker of the House of Delegates, presiding. (This session is a part of the Annual Meeting transactions which appeared in the September issue.)

REPORT OF CREDENTIALS COMMITTEE

Dr. D. J. Carlson: This is an Extraordinary Session of the House of Delegates of the State Medical Society. The Committee on Credentials has verified the registration of 49 delegates and 7 alternate delegates entitled to vote at this session of the House of Delegates.

I move that the attendance roll of delegates, alternate delegates and especially appointed delegates, totaling 56, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

Speaker Callan: This Extraordinary Session of the House of Delegates has been called to provide a means of communicating to the members some general information on the Kerr-Mills law in Wisconsin and some specific information on its implementation. Here in Wisconsin we call it HAPA, which are the initials for Health Assistance Payments Act, its official title.

In order to give you the most authentic information possible, we have been successful in securing the assistance of Mr. Wilbur Schmidt, Director of the State Welfare Department, and Mr. Elmer Rasmussen, Vice-president of Accident and Health of the Continental Casualty Company, the successful bidder for the contract to administer HAPA.

Mr. Schmidt has with him Dr. John Allen. Mr. Rasmussen has brought Mr. Frank Zepeda and Mr. Norman Rolfing of his organization to participate. Mr. Zepeda is in charge of the project for Continental. Mr. Rolfing is their Staff Planning Manager.

Because of the great interest in Kerr-Mills at this time and the manner in which it will be implemented, we have asked representatives of interested allied professions and organizations to be our guests for this Extraordinary Session of the House. It is thought that the better mutual understanding all of the vendors and those affected by Kerr-Mills have of the Act itself, the philosophy of the Act and its administration, as well as the procedures to be followed, the more certain we can all be that those who need it can and will get the best possible health care within its provisions.

So, we welcome and are pleased to have with us representatives of the Dental, Pharmaceutical and Nursing professions; also from the Wisconsin Hospital Association, the Clinic Managers Association, the Nursing Home Associations, Associated Hospital Service, Visiting Nurses Associations, and from the State Board of Health.

As you came into the room you were given a card on which to write questions that you wish to have answered by the speakers on the platform. Members of the staff will pick up your question card and supply you with another card in the event you want to submit more than one question. Please phrase your questions so they are in the general area covered today.

Mr. Schmidt will speak first on the Health Assistance Payments Act and the role the State Welfare Department and the County Welfare Departments will play in its implementation. Then Mr. Rasmussen will tell us of Continental's plans and procedures for handling claims from vendors and otherwise carrying out their duties as administrators. Following the Continental's presentation we will have the question and answer session.

■ REMARKS OF DIRECTOR OF STATE WELFARE DEPARTMENT

Mr. Wilbur Schmidt: As I understand the design for this session, it is to be more a workshop type of thing in which we get right into the details of how the program is expected to be operated, and thus to give you some background for later discussion and questions. With that in mind, I will begin by making some general statements regarding the benefits which are available under this Act.

Benefits

First of all, hospitalization: This Act entitles a person up to or not to exceed 45 days per illness for care in hospital or for care in hospital and in a skilled nursing home if the patient is transferred to the nursing home from the hospital; so it is a combined total of 45 days, otherwise 45 days in the hospital for each illness, whichever is indicated.

The benefits will also provide for physician's or surgeon's services while in the hospital or nursing home, and also for dental surgery if ordered in a case while in hospital or nursing home.

There are certain hospital outpatient services which may be necessary and which have been ordered by the physician, which can be provided.

In the extension of service to the home, there is included in this program fees for visiting nurses if this is ordered also by the physician and if provided by an accredited visiting nurse organization.

It provides for certain diagnostic, x-ray and laboratory procedures while in hospital, and lastly for prescription drugs, which prescription drugs may also be used in the home, not necessarily in the hospital.

This in a general way is an outline of the benefits to which individuals applying under this program would be entitled.

I might say in connection with these benefits that it is well known that when the Act was designed we should regard the Kerr-Mills program at this time as a catastrophic type of coverage for the elderly, realizing that setting limits at 45 days we were not even venturing into the field of long-term care of the chronic and infirm.

We did do some examinations statistically before the bill was put into final form, as to whether this ought best be 45 or 60 days or some other number of days; and bringing together some balance between what those who were providing leadership thought might be possible in financing at this time, together with the most practical limits in terms of the best kind of service we could provide to the beneficiaries, we came out with the 45 days. All of us who were connected with the designing of this Act realize that there will be other cases that will

exceed 45 days, and some other provision for their use will have to be considered.

We had some studies made on certain hospitals as to the number of individuals in the aid group who went beyond 45 days' hospitalization for a certain illness, and we felt we were getting the largest number of these cases within these limits.

Eligibility

As to eligibility, this of course is a program for residents of Wisconsin, although they can be absent from the State at the time they may be needing assistance under this Act, who have reached the age of 65, who are citizens but who at the same time are not currently receiving Old Age Assistance.

The eligibility requirements also include some references to income. The income for this program may not exceed $1,800 if single or $2,700 if married and living together. In this connection, it is not a case of being eligible if you are at $1,800 and ineligible at $1,801, however, because under the program any individual whose income exceeds this $1,800, and if single, who can show that his income has been used on health benefits such as the kind provided in this Act, can make himself eligible if by these payments he reduces his income to the $1,800 mark, and similarly for couples who may have $2,700.

In addition to this there is a test on the point of personal assets. Personal assets, under this program, are such as the allowance of the homestead in which the person is living, together with the properties surrounding it. His personal possessions within the household. His car. His television set. His furniture, and one thing and another, on top of which he may also have not to exceed $5,500 in other assets if single, or not to exceed $9,000 in other assets if married and living together.

In connection with this matter of income, there has been a change made in one provision of the Act as it was passed last fall, and this change was made in the April session of the Wisconsin Legislature. The original Act specified that income was to be the adjusted gross income as reported for federal income tax purposes.

When we came to the business of applying these considerations to the procedures for determining eligibility, we discovered that although this is a term which is used in the instructions to taxpayers for computing business income or professional or farmer income, there is no such term finally appearing on the Form 1040 individual income tax blank as such. And so our first concern was that, not finding such a term on the income tax schedule, a great deal of confusion would result in trying to determine what is meant by adjusted gross income.

We did not feel that the applicants themselves would thoroughly understand this and would be able to work it out for themselves from the instructional material in the tax law, and furthermore we don't think county welfare departments, in working with the determination of eligibility, would always be able to do it, either. So, this was one problem that we discovered in the original Act.

The second problem was that we believed the intent of the Act was to consider income, regardless of its form, as a total resource for purposes of determining eligibility under this program. However, we do know that for tax policy reasons, certain forms of income are excluded.

For example, the Federal Government does not tax interest on municipal bonds, so therefore the term "adjusted gross income" left the question open as to whether some forms of income should be excluded in fact under this program, and we did not think that was the intent.

Thirdly, there are two points of eligibility on the fiscal side, as I have already mentioned, one being income and the other assets. We didn't think the original Act carefully enough segregated or clarified what is income and what are assets. And so a bill was passed in the April session which changes the material that was in the original Act in a way so as to provide for a built-in definition within the program itself, and makes no further reference to the federal income tax blank.

In doing so, it might be said in summary that income is thought to be all forms of earnings, of pensions, of retirement or annuity situations, of social security and railroad retirement, and so on, all forms of income which may come into the person's hand during a year's time.

In connection with this matter of income, there is another important provision, and this is that any person who applies for eligibility under the program, and who is determined to be eligible, and who then applies for assistance under the Act, is required to pay toward the medical bill for which he is claiming help up to 5 per cent of his annual income.

Therefore, this 5 per cent will be applied to the same item, the same amount, as is used for purposes of determining income in the first place. Once having paid this 5 per cent, this accounts for his contribution for the entire 12-month period, although he may have a second or a third need to ask for assistance under the program. If this were to happen and his income had not changed, he still would pay only the first time around 5 per cent of his income in a 12-month period.

The application of that can be brought out by a couple of illustrations. This may be a single person who is otherwise eligible and whose income is $1,500. A hospital bill is incurred which amounts to $300 or $400. The man will be asked to supply 5 per cent of the $1,500 or $75, toward this bill, and the remainder would be eligible for benefit under the program.

Another kind of example might be the individual who is also single and whose income under this Act is $2,000—$200 more than the $1,800 provided for in the Act. He shows that he has used $200 of his $2,000 toward his hospital bill, and he will then be asked to put another 5 per cent of the $1,800 on top of the $200; in other words, he has to put up $290 out of his $2,000, and the remainder (whatever it might be) would be eligible under the program.

This 5 per cent will be an item which has to be determined at the time eligibility is determined, and at the same time (it goes without saying) that his income is determined.

Under the program we feel there may be some need to clarify a few terms which are being used. We speak of this program as being a program in which the settlements will be by contractor directly to the vendors of service. This simply means the suppliers of the several forms of service, the physicians, the hospitals, the pharmacists, the visiting nurses, and so on.

The term "beneficiary" obviously means the individual who is the recipient of the benefit.

The term "contractor" is something that has not been so common in the welfare and medical procedures in the past. In this case it is the Continental Casualty Company, who were the successful bidders for the contract for the administration of benefits, as they bid in open competition with other interested bidders and were successful, and thus were awarded the contract.

The matter of certifying eligibility: We have taken a step to delegate this responsibility to the county welfare departments, and we have done this because the county welfare departments already have structure and machinery available for handling applications. They have experience in it because they have been doing something similar to this for many years in other public assistance programs.

Also, the federal requirements state that in the case of this program there must be at least one face-to-face interview between a representative of the welfare department and the client. Our law, you may or may not know, points out that we can establish eligibility on the basis of a signed affidavit of the applicant. We are instructed under the Act to make more thorough investigation whenever we have reason to think we should, or reason to think there is some misunderstanding in the application, or some other question. But as standard operating procedure we are permitted to accept the signed affidavit of the applicant.

In spite of this, however, we still have to provide in the machinery, as the Federal Government requires, some system which will see to it that there is at least one face-to-face interview with the client, and we think therefore that the most economical way to accomplish this is to use county welfare departments.

I might add that another reason for it would be that in some communities we doubt if the load of applications and eligibility determinations would amount to as much as possibly the full time of one person; and if we were to seek to supply this service by the staff of the State Department of Welfare we think it might be costly, because we would have people traveling in fairly large geographical areas at considerable expense in order to make themselves available, as they should be, to the applicants of this program.

I might mention at this time that along with the regular routine procedure we have in mind, there will be ample provision made for emergency determination in those cases where the individuals may need this care and not foresee it before they became ill.

So, the procedure as we now have it planned will be that applications will be submitted to the county welfare department in the particular county in which the applicant resides, and at that point the county welfare department will examine the signed statement which the applicant will make, on his own behalf or an agent of his on behalf of the client, and determine on this basis whether the facts are complete, and, if so, whether eligibility can be established.

We intend to pre-certify, you might call it, by inviting people who believe themselves to be eligible to appear for determination even though they may not now think they will need help under the program. If determined to be eligible, we will see to it that they are given a card which will identify them as individuals who are eligible under the program.

There will be a form of identification which the suppliers of service may examine when the patient is received into the hospital. This will be a card that will bear the identification of the person, much in the same way as other forms of insurance programs do.

Having this card in one's possession, it will be the responsibility of the county welfare departments and the State to see to it that if any of these cards are in the hands of persons whose circumstances have changed and thus their eligibility has discontinued, that we take the proper steps to recover the card.

We do not wish to leave the impression anywhere that even having taken or admitted a patient with such an identification, some later discovery of ineligibility is going to result in loss to the supplier of the service, for we do not have this in mind. We will try our best to keep up. It is a responsibility of each applicant to inform the county agency if circumstances do change. He has just as much responsibility to do this in all honesty as he has to be honest with his first application. We think it will work.

In this connection I might say that I do know of some of these Kerr–Mills medical plans that started off in other states, where a thorough home investigation, of the same kind that is required for Old Age Assistance, was made a part of the law, and the thing that happens here is that you can run up a very high cost in terms of the benefit which is finally paid out.

An example: If it takes $100 worth of staff time to run down responsible relatives and residents and facts about income, and so on, simply to make somebody eligible for a $300 hospital bill, this does not make much practical sense. Hence, the decision here is to go as far as we can with a more simplified application procedure which does permit application by affidavit, and only selective investigation wherever this seems to be indicated.

The county welfare department, having seen the applicant and having determined that he is eligible, will see to it that he receives such a card, which will be the kind of thing that most of you will see in your clinics or hospitals when the case is received.

Program Estimates

You might be interested in knowing about how large a program we may be expecting, and something about how we sought to estimate the cost of it. The estimating of this program was not easy, and I might say it continues to be very speculative, because the kinds of facts one usually needs in a statistical problem of this sort, based upon experience, is simply not available because we have not had experience with this kind of program with this age group, which tells us enough about how often and in what numbers they become ill each year, and to what extent they are in need of hospital care. But there are some facts that can be put together which I think give us rather safe direction in planning for the financing of the program and in having some knowledge of what we might expect in the way of volume.

I would start by saying that in Wisconsin today we estimate we have something like 432,000 individuals in our population who are over age 65, and hence on that point alone would be at risk under such a program. We believe that about 60 per cent of these individuals would be eligible on the basis of the income levels which are prescribed under the Act, and this would produce about 259,200 such persons.

Then, we know that among those persons there are already some who are cared for under the Old Age Assistance program and would have no benefits to be gained from this, and still others who are in county institutions, mental hospitals, tuberculosis sanatariums, and so on. Also, certain veterans are included in this number, who have rights from the Veterans Administration and who therefore would not be candidates for this program.

We think that after removal of these people we will still have about 194,000 to be thinking about in terms of this program.

After we apply the liquid assets test—which we must, as you will recall, we think it reduces the number by another 19,400, as we will find about 10 per cent of these people with an excess of assets over the allowed amount, this gives us about 175,000 persons in our age 65 and over population whom we think we have to give some consideration to in thinking about the volume of this program.

There are some studies of recent dates that we are relying upon. They may not be representatives of our State, but they are the best that are available to us, and they tell us that about one out of six such persons, regardless of who they are, will need hospital care within the year. So, this is about 29,167 individuals.

There have been some confusing studies on the average length of stay in a hospital of late. We have seen some figures that showed an average of about 22 days, others with different figures. The most re-

cent and warmest set of figures we have on this show an average length of stay of 15 days.

We think the terminology is important here, because we think this may have come down in recent years from a larger number because of the tendency to develop more and more of the nursing home, infirmary, convalescent kind of facilities which may not be classified under hospital care.

At any rate, we are depending on these 15 days. Thus, we produce total hospital days of 437,505. We think an average of $30 a day or a total of $13,125,000.

We have to make some adjustments in this $13,125,000. First of all, we have to adjust that because we cut off at 45 days of hospital and nursing care total; so we think that when we take this out—that is, the claims which exceed that amount—we have to take out about $1,325,000. Also, we have to take out for the 5 per cent contributions that people are going to make—that is, the 5 per cent of their income toward the claims they make against the program. That takes out another $1½ million, which leaves us with $10,500,000, and 29,000 people for whom transactions are being considered.

The $10,300,000 is reducible more than that on account of the evidence showing the number of these persons who have some form of hospital agreement of their own, and who therefore would not duplicate under this program. We have some indication that about two-thirds of these individuals could not be expected to have any other form of hospital insurance. We think that about 7 per cent of them will have some form of insurance, but it will be only about 30 per cent of what would be needed to cover the full amount this program will allow, and we think about 8 per cent of them have about two-thirds of the coverage that this program allows, and that about 18 per cent of them would have about 85 per cent of the coverage that this program allows.

So, we think that out of that $10,300,000 we can expect almost $3,000,000 to come from other forms of insurance, leaving this program about $7,350,000.

Up to this point we have talked about hospital or nursing home care. In addition to this, there are other studies which show that 40 per cent of those hospitalized out of the total 29,000 will need surgery or other special physician services. And so we produce a figure of about $1,750,000 for physicians' services. We then get about $9,100,000 for the combination net.

As I said earlier, there are some things we have to add to this, which will be the drugs, the visiting nurse services, and some other forms of physicians' services not included in this sample. We think we have about $1 million for that in a $10 million program.

Our estimate up to now has been that this could mean a program of benefit amounting at state and federal cost to about $10 million per year. This could go up from there, but that seems to be the most reliable baseline now available for estimating.

I would like to throw in another consideration, however, for it may be known to some of you that the appropriation that we have does not equal this amount. Actually, it is $6 million, which is there for the year beginning July 1.

This is not alarming because, as honestly as we are attempting to establish the statistical potential of this program, which we think is $10 million, we also know that in no other case across the country has the statistical potential of this program or any of the new programs we have soon flourished this fast. That is, what look to me to be the potentials of the program are not realized in the first, second, or sometimes even the third year.

So, we think the $6 million that is there for July 1, 1964 to July 1, 1965 will be sufficient to finance the program.

I might say that out of this figure $2,842,500 of this is an appropriation from State revenues, and the remainder is the share paid by the Federal Government. So, it is the combination of these two that we produce an almost $6 million figure.

We think that at the most we might see 28,000 or 29,000 people. We think it is going to be less the first year. We guess there might be 15,000 transactions that will take place this first year. Perhaps 16,000. One of the things that throws us off in thinking about the number of people is the unknown, the extent of the drug program. We really don't have any basis for estimating that.

So, this is the way we came about our appropriations and what we expect to see in terms of volume for the next year or two.

Responsibility

In conclusion, I think all of us in this room have in one way or another a responsibility and interest in the success of this program. I know that, as far as the State Department of Public Welfare is concerned, it wants to have the clearest kind of understanding with individuals, both on the side of the recipients and beneficiaries and on the side of suppliers of services.

We seek to answer questions as clearly as we can when they are raised, and we also recognize as much as anyone, I think, that this cannot be any one department's show, or a matter which can succeed without the cooperation of everybody.

Included in this room are a number of people who will be called upon to supply service under this program. I think each of you will feel the same responsibility that we do, which is to make some kind of examination, brief though it may be, when the applicant appears, to be sure that the applicant is clearly in possession of the eligibility card which he has, and then to supply the best kind of judgment as physicians or as other suppliers of service in terms of what the person really needs.

I think the best way I can express what I believe the philosophy of the program to be, and one against which the supplier of services measures his own judgment, is that the point of this is recognition of the fact that income dropped so much for 60 per cent or more of our retired individuals at retirement age that very often one drastic hospital bill, even in the amount we supply in this program, is enough to wipe out and make most difficult to recover for a long time the small savings, or many months of whatever income they can look forward to.

The hope is that by seeing that such individuals have some support and some place to go for protection, they will not tend to reduce their means to the point of total dependency and, much sooner than otherwise, become candidates for the longer-term care under Old Age Assistance, perhaps.

Secondly, that some people in this age group may be fighting off attention to health problems which they should get simply because they just don't know how they are going to pay the bill. The hope is that as a preventive measure, earlier attention to the health problems of this age group can save them—or at least postpone, if not save them—from more complete deterioration, and a long life of infirmity possibly in a nursing home or in somebody's hospital.

Against this, the suppliers of service measure whether it is necessary care, is it necessary to preserve this person's health, is it approaching an emergency, and so forth.

If there are any questions, we will seek to get the answers to them. We are trying something new here, and it is going to mean that everybody will have to work together on it. I am certain, as I have always been in the past that we will find a "bug" or two here and there in the machinery, and when we do we will do our level best to correct it. I hope we can

have the same kind of spirit on the part of others who will participate in the program.

We have confidence in the Continental Casualty Company, and I think we will be hearing from them in a few moments as to what their plans are. As partners in the administration of this, as far as we have gone to date, we ought to get along together pretty well.

I want to close by saying again that I appreciate this opportunity to appear before you. I have enjoyed good working relationships with the headquarters staff of the State Medical Society. We had numerous joint meetings at the time this measure was being prepared, but I wouldn't say it ended there. We have had other cordial relationships in other areas of public welfare service. It is a great pleasure to meet with you today.

■ REMARKS OF VICE-PRESIDENT OF ACCIDENT AND HEALTH, CONTINENTAL CASUALTY COMPANY

Mr. Elmer Rasmussen: I think I ought to quit while I am ahead. Mr. Schmidt has already covered the ground pretty well. I believe my main function is going to be to tell you something about Continental Casualty and how we propose to implement the Kerr–Mills program in your State.

Our people at Continental Casualty have been most favorably impressed with the spirit of cooperation shown by all parties who have had anything to do with the implementation of Kerr–Mills in the State of Wisconsin. Mr. Schmidt is to be congratulated upon the caliber of the people on his staff in the State Department of Public Welfare. We have found them easy to work with in setting up the machinery for administration of the program. Not only do they know their jobs thoroughly, but they have a good understanding of the problems with which Continental is concerned as fiscal agent. This has created an atmosphere which assures the success of the program.

It has been estimated that payments under Kerr–Mills in the State of Wisconsin will approximate $10 million a year. Continental, as fiscal agent, will be responsible for seeing that this money is disbursed promptly and accurately to the purveyors of medical care, all of whom, I believe, are represented here today.

Since you are directly concerned, I think it only fair to tell you something about the company with which you will be dealing—even at the risk of seeming publicity-minded, which, I assure you, is not my intent.

Continental Casualty Company

Continental Casualty Company is a member of an eight-company sales and service group with combined assets of nearly $2 billion, capital funds of $445 million, and nation-wide all-lines agency and claim paying facilities. The combined premium income of the companies in 1963 was $778,656,000. This means that "Continental National American", as the group is known, ranks as the third largest stock agency group in the insurance industry.

Continental Casualty Company has made a substantial contribution to the extension of health insurance to the aged. We were one of the first companies to recognize the need for this type of protection, and we now estimate that we are providing coverage for health care expenses to about one million persons over age 65.

During the last ten years we have learned a great deal about the problems that are peculiar to this particular group of policyholders. We are convinced that we can apply this knowledge to the administration of Kerr–Mills in Wisconsin, and, with the cooperation of all of you, develop a program in your State that will be second to none.

So much for the size of the Continental National American Group and our ability to perform satisfactorily under the contract which we have been awarded. Now for our philosophy or, if you prefer, our company policy with respect to an undertaking of this kind.

Policy

We subscribe to the principle that the federal and state governments should participate in the financing of medical care for those persons over 65 who are in need of economic assistance, and that those who are able to finance their own medical care should do so, whether they are over 65 or not. This, we believe, exemplifies the American system of free enterprise.

Kerr–Mills may not be the final answer, but it is the best one that has been suggested to date. Not only does it provide adequate assistance for those who have not been able to buy protection for themselves, but it gives those who can afford such protection an opportunity to determine for themselves the type of protection which is dictated by their own needs. No form of government-sponsored program which applies to all persons regardless of individual circumstances can accomplish this objective.

We believe that the physician-patient relationship, and the relationship of other purveyors of medical care with patients, should be maintained in an atmosphere which guarantees that none of the parties involved has to be concerned about ability to pay.

Purveyors of medical care are entitled to expect a reasonable fee for their services. Doctors are noted for their willingness to treat patients on a charitable basis where necessary, but I am sure that neither the doctors nor the patients enjoy this arrangement. Kerr–Mills, of course, is paid for by the taxpayers, and practically everyone has been a taxpayer at some time in his life.

Although a means test is used to determine eligibility, this does not, in any sense of the word, place the recipients in the charitable category. I prefer to believe that they are people who have paid for these benefits in one way or another and, therefore, are only receiving that which they are justly entitled to.

It is my company's belief that an insurance company should be dedicated to the principle of public service, just as all of YOU are, and I ask you to believe that this was the motivating factor behind our decision to bid for the contract to administer Kerr–Mills in the State of Wisconsin.

Some states have been slow in implementing the Kerr–Mills Act. Others have done so, but on a self-administered basis. The State of Wisconsin is to be congratulated upon its decision to delegate the administrative responsibility to an independent contractor. I would have to say this even if my own company had not been awarded the contract, because it stands to reason that an organization which is accustomed to dealing with matters of this kind can do so more efficiently and less expensively.

Administration

We plan to make full use of our electronic data processing equipment in implementing the program. This will guarantee prompt, accurate payments to vendors, and also produce with a minimum of effort the statistical detail required by the federal and state governments in addition to satisfying our own needs in this respect. Naturally, we hope that the data thus obtained will be helpful to us in redesigning our current benefit programs for those over 65. It could be said truthfully that this may be the only material advantage that we will gain from our participation in this program.

As has been said so often, the cost of medical care has risen and will continue to rise. We recognize that this increased cost must be balanced against the advances in medical science made possible by new techniques and improvements in the facilities for treating patients—to say nothing of the fact that doctors were notoriously underpaid up until ten or fifteen years ago. (Some of you in this audience probably feel that you are still in this category.)

What I am leading up to is that it is difficult for insurance actuaries to determine current premiums in relation to future costs unless a reasonable fee level is maintained. This applies with equal force to benefits paid under Kerr–Mills. If the success of the program is to be assured, it is necessary for everyone to adopt a realistic attitude. The cost of treatment should be held to a reasonable minimum, and any tendency toward over-utilization of services by the patient or anyone else must be carefully guarded against.

As pointed out by Mr. Schmidt, it is estimated that there are over 400,000 persons in Wisconsin who are 65 or over. Of these, 175,000 will qualify under Kerr–Mills. With the advances in medical science, both of these figures are bound to rise considerably in the future. It is our fervent hope that our paticipation in Kerr–Mills will prove that it is the answer to our national problem, augmented by voluntary forms of coverage offered by my company and others in the industry to those who can afford to budget their insurance programs during their working years.

The actual administration of the program will be relatively simple from our standpoint. Every attempt has been made to avoid complicated procedures. All vendors will receive full instructions, together with the forms which are required for submitting their claims.

Generally speaking, the relationship between the various vendors of medical care and the contractor comes into being when the vendor submits the claim form and it is received by the contractor.

Preceding this relationship is the distribution of the information and instruction guide to all known eligible vendors. This guide will be mailed about the middle of June. It will contain information relative to the program and instructions regarding the proper completion and submission of the vendor claim form.

Vendor claim forms are to be mailed to the contractor at the end of each month so as to be received by the 10th of the following month.

Many of the statistical requirements are unique, and hence it was necessary to design separate and distinct vendor claim forms for each of the various vendors participating in the program. In many respects the vendor claim form parallels the billing forms currently being used for the Old Age Assistance Program and, wherever possible, the new statistical requirements were considered in the light of the former in designing the vendor claim form.

The information and instruction guide will contain a sample of a properly completed claim form for your specific category of vendor.

Payments will be made to vendors within 30 days or less, and the reimbursement statement will identify the beneficiary and the month for which reimbursement is made for services rendered to eligible beneficiaries.

To avoid delays in processing vendor's claims, we ask basically two things: (1) that the vendor claim be submitted promptly after the close of the month, and (2) that it contain all required information. Information critical to the processing of a vendor claim form includes your vendor number, which will be assigned by the contractor, and must appear on your claim form; the beneficiary's number, which is assigned by the County Department of Public Welfare and must also appear on your claim form, and your signature on the bottom of the claim form indicating compliance with the certification statement appearing on all claim forms and required by the law.

In the early stages of the program, we must honestly anticipate minor difficulties concerning the completion and prompt submission of vendor claim forms. Prompt response to the contractor's inquiries regarding incomplete claim forms is essential.

Claim forms will be supplied by the contractor. An interim supply will be included in the mailing of the information and instruction guide. Additional forms are available from the contractor.

All correspondence and vendor claim forms are to be mailed to:

Continental Casualty Company
Box VV
Chicago, Illinois 60690

Thank you very much. It has been a pleasure to be here, and I am sure our relationship will be very happy in the future.

Speaker Callan: Any guest at this session who wishes a transcript of the proceedings may write to the State Medical Society of Wisconsin in Madison this week, and single copies will be made available without charge.

Are there any questions for the panel?

Question: At the death of a recipient must the estate pay for the benefits received?

Mr. Schmidt: The answer to the question is that under the law, while there can't be any lien applied against property, as is now done under Old Age Assistance, the law does provide that after the recipient and spouse have passed on, if there is an estate, the State may enter a claim against that estate in the amount of the benefits paid. The claim is in the status of a general creditor. It has no other preferred standing.

Speaker Callan: "What if a person with the same illness is hospitalized three times in one year for 45 days each time, but with a 30-day interval at home between these hospitalizations? Is he still eligible?"

Mr. Schmidt: No. If this is for the same illness, the patient is only eligible for one period of hospitalization of 45 days unless separated by a period of six months. There can be reapplication for benefit under the program for a different illness not related, as long as there is a lapse of time between release from one and before the claim for another of at least 30 days.

Speaker Callan: "Are visiting nurse service benefits limited in time as in hospital care—that is, 45 days?"

Mr. Schmidt: I was just checking with Mr. Lucas and Doctor Allen, and I made an error in the answer to the previous question. It is not necessary for a 30-day separation between two illnesses as long as they are separate illnesses.

As to the last question, there is no limit of 45 days put on visiting nurse services.

Speaker Callan: "How will the fee schedule be made?"

Mr. Rolfing: There are no fee schedules as such. The benefits provided are that of "reasonable and customary" in the area in which the service was rendered.

Speaker Callan: "Will declaration of assets be investigated or taken at face value?"

Mr. Schmidt: Under the law they can at all times be taken at face value. However, we will have examples, I think, where it will be clear to someone in the county working with the applicant, if they don't quite understand or if for some reason they may feel the statement is not complete, and in this case they

would be free to make a more thorough investigation. As a regular operating procedure this can be taken at face value.

There is no relative's responsibility requirement under this Act, as you may know about under other forms of public assistance; so, the deal is entirely between the applicant who is asking for benefits and the certifying agency.

Speaker Callan: "How often do eligibility cards have to be renewed?"

Mr. Schmidt: At the present time we are planning to have an eligibility card issued for a one-year period, and then we require recertification at the end of that time. I hope this won't turn out to be too long a time, but this is the way we are planning it now, and thus we will ask that these cards all be re-certified at the end of 12 months.

Speaker Callan: "Does the client keep home and property? Does the $9,000 value of assets include the home, or is it just movable assets?"

Mr. Schmidt: The $9,000 is on top of or does not include the home. This is in addition to the home. If the home is being lived in; and any personal possessions, car and other things which the individual has. In addition to this, these are other forms of ownership, whether this be income-producing property, or investments, or what-have-you. But the home is not included in the $9,000. This is in addition to it.

Speaker Callan: Mr. Rasmussen, "Is payment made to the patient?"

Mr. Schmidt, "How soon must application be made after onset of illness to recover and receive payment from onset?"

Mr. Rolfing: The contract provides that the payment must be made to the vendor. We cannot make payment to the beneficiary.

Mr. Schmidt: If I understand the question, we haven't set any certain amount of time as the limit, having gone into the hospital for an emergency, and in order to still be determined eligible. Upon admission, if we find this person does not have certification for eligibility already established in the State, and he wishes to apply for it, this ought to be done right away. If so, I don't see any reason why it could not be processed in a way to catch up with the illness for which he is then claiming.

Speaker Callan: "Who will decide what fees are 'usual and reasonable'? What will happen in instances of fees that appear unusual or unreasonable?"

Mr. Rolfing: To begin with, we have a little experience in this area, having written contracts on "reasonable and customary" for some time. The contract provides that we have to have professional consultants and fees which are just. Fees that people feel are unusual will be discussed with our consultants. After this we have an obligation to discuss this with the physician charging the fee that we feel is not quite reasonable, and try to negotiate the fee with him. If we can't come to an agreement, then we have an obligation to bring the matter to the Welfare Department's attention for further negotiation and arbitration.

Speaker Callan: "What is the cost of administration of the program?" I don't know if you wish to divulge that.

Mr. Rasmussen: If I understand this relation to the entire program, our unit bid was $1.14 per unit. I don't think we have determined yet how many units will occur in any given period of time.

Speaker Callan: "Please reconcile these statements. Mr. Rasmussen said this is not charity but something earned. How then can the State file a claim against the estate?"

Mr. Rasmussen: I don't think I can answer it for the State of Wisconsin. My statement was a philosophical one and expresses my own feeling on matters of this sort.

When I say it is not "charity", I think the people who have worked all their lives and who have paid taxes are entitled to be taken care of after they are 65. As I said earlier, I feel that the ones who can afford to purchase their own protection for their later years should be given an opportunity to do this also. Perhaps Mr. Schmidt can answer the question about what the State's position would be.

Mr. Schmidt: I think you are seeing here one of the things that grows out of the legislative process. I believe there is a common attitude that isn't far away from Mr. Rasmussen's view, that these individuals have earned something in the way of protection from long years of good citizenship and responsibility. But when you come to join these considerations in a piece of legislation, and enter the state into a new area of cost, very often it is necessary to reckon with some other values—one being that it is fine, no reluctance to see to it that the elderly receive this consideration, but after they have had the opportunity to use all of what they own and have been served, perhaps in contest with otherwise inheritances, the state ought to make some bid for the return of some part of its investment.

I think it is just a case of a piece of legislation having to consider all these values, and in one way or another bringing them together into a piece of legislation which is in fact passable. I think you will have all kinds of philosophies on this point, but I believe it is the desire of the Legislature and others who worked with this not to inflict upon elderly people this stigma of failure and dependency on the public.

Speaker Callan: Most of these questions are directed to Mr. Schmidt, and I think it would be quite unfair to expect him at this time to come up with the details on these many specific questions.

I have a few here, though, that I am sure will be sort of general. "Is a guide for charges to be established?"

"Who will determine the physician fee schedule?"

"Will medications—that is, prescriptions—be paid for on an outpatient basis, not in conjunction with hospitalization?"

Mr. Schmidt: First of all, I think we should remind ourselves again that the law says that fees are to not exceed the usual and customary fees, and are not to exceed the average paid for such services within a general area. If that were as far as we had to go with this, one could do it possibly a little more simply. But there is also a requirement upon us by the Federal Government that we have some kind of an expressed fee schedule which they can check us against from time to time, as the Federal Government has substantial participation also.

So, our view of the whole thing is that by arrangements which will be developed between the contractor and the representative of the various professions, medical people, physicians, meaning by that hospitals, and so on, in the different areas, that what is the meaning of the term "usual and customary" will become, in that particular area, the fee.

So, as far as the records go, any kind of a fee schedule we supply will reflect this, and hence we will not be looking forward to the publication of a grand, detailed, State-wide fee schedule, but instead the development of this principle of "usual and customary", and by the devices available to the contractor for working these agreements out.

Mr. Rasmussen: May I add something to that, Mr. Schmidt? Just one thing. We have had a great deal of experience in dealing with the problem of "usual and customary" charges. I am happy to say that the State of Wisconsin has been remarkably free of any controversy in this respect, which indicates that our participation in this program, from the standpoint of trying to determine what is "usual and customary", is going to be free from any trouble. I don't think we will have any trouble at all getting along with people on this.

I could mention some other states where this problem is prevalent, but I won't. Wisconsin is not one of them.

Mr. Schmidt: Another question is asked: "Can prescriptions be supplied though they are part of an outpatient service and not included in a hospitalization episode?"

The answer is yes, they may. They can be prescribed by the physician and can be taken not necessarily while in the hospital. They can be taken at home while the person is an outpatient.

Speaker Callan: The "usual and reasonable" fee seems to be a source of some misunderstanding. "Are reasonable, customary charges interpreted as usual welfare charges, or the usual charges of those not having limited incomes, as there is a difference in most practices in the method of charge?"

It is the usual, reasonable fee, not the usual welfare charge.

"Will preexisting conditions be excluded?"

Mr. Rolfing: There is no limitation in that regard.

Speaker Callan: "Will the patient's 5 per cent of income liability to the bill for services have to be paid before any benefits are paid under HAPA?"

Mr. Lucas: He can either obligate it or pay it.

Mr. Schmidt: We are requiring that the individual or patient show that he has not necessarily paid but has at least obligated himself to the 5 per cent. I think this will leave some responsibility on the part of the supplier of the service to see that this 5 per cent is paid, but it will not in any way set aside the right he has to the full benefit.

Speaker Callan: "Mr. Schmidt, does $6 million include administrative costs in your Department and fees to Continental?"

Mr. Schmidt: No, it does not. We had to make a very round estimate, and how it finally came out was that against the $6 million program we threw in about a 5 per cent factor; in fact, about $315,000, both federal and State money, which is available for administration, and this would be the amount to cover the services of the welfare departments and the contractor.

I might say here that counties, although they are being used in the declaration of eligibility, will not as counties finance any part of it, because each of them in filing proper claim with the State will be reimbursed 100 per cent for their administrative expenses in connection with this program.

Speaker Callan: Mr. Rasmussen, "If the patient is required to pay 5 per cent of his income, wouldn't a direct contract with Continental Casualty be cheaper and result in greater benefits paid to hospitals, and the patient more assured of coverage which does not depend on income and assets? I am basing this question on the fact that you stated you have been one of the leaders in providing health benefits to those over 65."

Mr. Rasmussen: If I understand the question correctly, it is whether Continental could make insurance available on an individual basis to people over 65 in Wisconsin rather than under Kerr-Mills. Is that the sense of the question?

Well, this would assume that the people who are now eligible under Kerr-Mills could afford to budget their insurance costs before they became 65. I believe the intent of Kerr-Mills is to take care of people who can't.

Usually the company is writing individual insurance, that is, on individual policyholders and not under a plan such as this. You have an agency situation involved also, where the agency expects to be paid a commission. So, I would have to say your program in Wisconsin is the most economical that can be devised.

There is another factor involved in this too, and that is that if a company were to provide insurance on this basis it would have to pay the state premium tax. I don't remember what it is in Wisconsin, but it must be 2.5 or 3 per cent. Under this program no premium tax is applicable.

Mr. Schmidt: Mr. Speaker, I would like to add something here. I don't think we should assume that the largest number of people (even though I gave a figure of 60 per cent under the $1,800 and $2,700 mark) are going to be at $1,800 and $2,700. There are not going to be so many 5 per cents of this amount. The 5 per cents they are going to put on are more likely to be on figures like $1,000 or $50. This isn't enough to buy much in the way of a total package and plan through the devices of insurance premiums.

You know, the average social security payment in Wisconsin now, to a person over 65, is probably not much more than $80 a month. A lot of these people will not have much more than that.

Speaker Callan: There are several questions about outpatient services provided for, including diagnostic workups. Mr. Schmidt or Mr. Rasmussen, can you answer that?

Mr. Rolfing: The policy does provide for outpatient hospital diagnostic workups, including therapeutic work also. There are no fees. Here again it is the customary hospital charges.

Speaker Callan: There are other questions relative to how Milwaukee County is affected by this program. "Milwaukee County now has no welfare schedule that I know of. Must we set this up?"

Mr. Schmidt: Actually, one of the things that you probably know about Milwaukee County's usual welfare system is that it has its own general hospital, and it works out a great deal of these procedures within its publicly operated organizations. But in this program, under the terms of the law, the individual is to have a free choice of hospital and of physician, and this means that, like in any other community in Wisconsin, any of the hospitals or any of the physicians whom the applicants are asking to serve will have to abide by the usual and customary fee charge.

If any of them choose to use the County General Hospital, they will have to supply a fee schedule for settlement of their claims, in the same fashion as any other hospital would. At least this is how I see it at the present time, and I think there is no question but that this is an interpretation of the Act.

Speaker Callan: There are several questions on what constitutes a "skilled" nursing home. "How many exist in Wisconsin at this time?"

Mr. Schmidt: In Wisconsin the nursing homes are licensed by the State Board of Health, who in turn, in connection with their responsibility, have been seeking to classify and establish what constitutes a skilled nursing home under this terminology. This has to do with the extent of the nursing coverage by registered nurses that is provided, the adequacy of

patient care, the connection with physicians, and so on, so that proper attention is given.

Of course, in this case we are talking about individuals who are transferred from the hospital and who are already under some doctor's order. It is a nursing home which will meet these conditions as determined by the State Board of Health that is the licensing authority in this State for proprietary and nursing homes.

Speaker Callan: "Is all this money allocated to medicine? What per cent to the other health fields?"

Mr. Schmidt: A total range of benefits is: Hospital, nursing home on transfer, physicians, dental surgery, dentists for dental surgery in the hospital, pharmacists on account of the drugs, and nurses on account of the nursing service.

Speaker Callan: "Assuming a former resident of Wisconsin moved back to the State and applied, is there any rule regarding time interim of living out of state?"

Mr. Schmidt: There is no term of residence requirement under this program. "Residence" under this program is a matter of intent to reside some place, and hence he would not be asked to remain here a year, or something else, as in other programs. Coming here to reside makes him eligible for the program. These things sometimes require interpretation, and incidentally is one of the reasons why there has to be a face-to-face interview, because one very often has to distinguish between whether somebody has come here for a visit or if somebody came here with a clear intention of remaining.

In reverse of this, an elderly person under this program, who is a Wisconsin resident, may be visiting his children, let's say, in Chicago, and would take sick there and could apply for the benefits under this program, even though his illness actually took place outside the State.

We do not have a term-of-residence requirement. It is instead whether or not the individual arrived here with the intent to reside here.

Secretary Crownhart: The Secretary has asked for permission to ask a question to resolve his confusion.

In the development of the specifications under which the bid was let, there was indication that there would be annual renegotiation of fee problems with the various county medical societies. I do not feel the record, at least, is clear on just how the State Department and Continental intend to do this. Is it going to be by mandate out of Madison, mandate out of Chicago, or in cooperative relationship with county medical societies?

Mr. Schmidt: As far as I am concerned, Mr. Speaker, on behalf of the Welfare Department I think it is going to have to be by cooperative arrangement. I think that "usual and customary", an average for this kind of service, or general for this or that kind of service, is not something that is laid down but is produced by the profession or the particular industry that is supplying the service.

I think it means that we don't have special rates either way up on the high side or that we try to drive bargains way down on the low side, but that we take our place right along with other users of health services on the basis of the usual and customary and agreed-upon fee levels.

I think we have in our Public Assistance system some machinery, county by county, for working through representatives of physicians, for example, or of hospitals, in coming to some understanding as to what the fees ought to be. Certainly I am looking forward to this being a negotiation in the spirit of cooperation.

Speaker Callan: Thank you, Mr. Schmidt.

The State Medical Society of Wisconsin wishes to thank the participants, Mr. Schmidt, Doctor Allen, Mr. Thomas Lucas of the State Welfare Department, Mr. Rasmussen, Mr. Zepeda and Mr. Rolfing of Continental Casualty Company, and all our guests, who were nice enough to come here today for this informative session.

The meeting is adjourned.

First Month's Costs of Kerr-Mills

In September the State Department of Public Welfare announced that the first month (July) of operation of the Kerr–Mills medical assistance law in Wisconsin cost $83,000. This amount was paid out to 365 persons over 65 years of age.

Of the total payments, averaging slightly over $229 per individual, 88 per cent went to hospitals, 8 per cent to physicians, and 4 per cent to nursing homes, dentists, pharmacists, and visiting nurses services.

At the end of July there were 14,176 persons eligible to receive aid. A person may establish his eligibility before he becomes ill. The law limits aid to persons over 65 not receiving old age assistance, with an annual income of $1,800 or less for a single person and $2,700 for a married couple.

For the fiscal year ending June 30, 1965, close to $6 million is available for aid, with the state's share $2.8 million. Eligibility of persons is established by local welfare departments.

Chest Physicians Announce 1965 Essay Contest

The American College of Chest Physicians offers three cash awards to be given annually for the best essay prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs). First prize will be $500; second prize, $300, and third prize, $200.

Winners will be announced at the 31st annual meeting of the American College of Chest Physicians June 17–21, 1965, in New York City.

The official application form, sample copies of the journal, and additional information may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611, U.S.A.

New Publication on Birth Defects

A monthly abstract service covering articles published in 2600 journals in 27 languages has been launched by The National Foundation to make all current work on "Birth Defects" quickly available to all workers in this broad area. Subscriptions to this service are $5.00 per calendar year (12 issues). Write to The National Foundation, Supply Division, Room 555, 800 Second Avenue, New York, N.Y.

the wisconsin medical journal

VOLUME 63/NUMBER 11 NOVEMBER 1964

Studies in Human Communication in Clinical Settings Using Sound Film and Tape

WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

By HENRY W. BROSIN, M. D., Pittsburgh, Pennsylvania

■ IT IS PARTICULARLY fitting that an article reporting experiments on human language and communication be included in a volume dedicated to Dr. W. S. Middleton. Among his many virtues as physician, teacher, and leader was his ability to communicate accurately, economically, and with a minimum of ambiguity. These are extraordinary qualities and reflect the integrity and intellectual power of Doctor Middleton. All of us who were his students and colleagues are fortunate to have this opportunity to express our gratitude.

The Crucial Need for Better Recording. Physicians are highly trained to examine patients carefully and methodically for the purpose of diagnosis and treatment. They perfect their individual skills throughout life in methods of history-taking and direct observation of physiological systems and the patterns of behavior involved. Modern improvements in instrumentation and recording are only extensions of these basic methods. In fact, instruments have been called the prostheses of the scientist. We are acutely aware of the progress made in physiology, biochemistry, microbiology, and the medical-surgical procedures developing from them. We have not made comparable progress in the arts of interviewing with stable records which can be studied repeatedly. However, early work in this area can be reported in part. It seems worthwhile to do so since the probability is high that more aspects of human behavior will become amenable to systematic study as we improve our recording concepts and tools.

The common-sense observation, "It is not what you say, but how you say it that matters," focuses upon a central problem in the systematic study of human communication. Since the centuries when a nonideographic, phonetic writing was perfected by the Sumerians in the valley of the Tigris and the Euphrates between 3000 B.C. and 2000 B.C., we have become accustomed to a manner of writing and printing which is somehow fixed and independent of speech. Yet we know that for many purposes writing is not an adequate substitute for face-to-face conversation. This is particularly true in the clinical setting where the interaction between the patient and the doctor is often complex and

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subtle, and therefore not easily summarized in words.

Language as a Network of Communication Systems. Linguists who have a background as cultural anthropologists have contributed importantly to researchable concepts and techniques. Just as a physician-biologist studies the increasing complexities from the molecules which make liver, blood or muscle cells, to the organs and organ systems, and then tries to understand the workings of all these elements in the total living man in his natural environment, so the linguist-anthropologist describes the units of language called phonemes, morphemes, and the like, in the larger organized units of which they are a part. The basic elemental sounds and the words and phrases built up from them are further built up into larger units called sentences, paragraphs, essays. "To use a chemical figure of speech, they form compound molecules which can be analyzed as structured; they are not mere physical mixtures."[1] Each of these units may be included in larger transactional units such as the patient-doctor relationship, the hospital or clinic program, the family and job dynamics, the various community health programs, and the economy of the area. It will probably include references to the past experiences of the patient and his future expectations which motivate and guide him, as well as his immediate clinical problem which brings him to the doctor. The clinical method has many resemblances to these natural history methods but includes judgments which are based on observations and inferences which are implicit and unverbalized, and therefore unavailable for public review. Context or communicational analysis is a natural history method which aims at making these relations between units at each level of organization as explicit and public as possible by presenting recorded data which can be examined by numerous specialists in order to reduce the bias of observers.

The theory that language is a complex but structured system along with many other systems which enable a culture or community to operate, such as food-getting, toolmaking, ethics, and religion, was developed by Malinowski, Sapir, Bloomfield, and others with numerous fruitful experimental approaches. One of these resulted in the insight by Sapir that there is a "tendency of symbolisms to constellate in accordance with an unconscious or intuitive logic which is not necessarily based on experience with the stimuli in their normal, functional aspect."[2] Further considerations of the stability of patterning in language systems even though the content varied, led Sapir to see the value of linguistic analysis to psychiatry and vice versa.[3] He understood that the mechanics of unconscious patterning which were so obvious in his experiments applied also to other forms of cultural behavior such as posture, gestures, and body movement. Sapir wrote:

> Gestures are hard to classify and it is difficult to make a conscious separation between that in gesture which is of merely individual origin and that which is referable to the habits of the group as a whole. In spite of these difficulties of conscious analysis, we respond to gestures with an extreme alertness and, one might almost say, in accordance with an elaborate and secret code that is written nowhere, known by none, and understood by all. But this code is by no means referable to simple organic responses. On the contrary, it is as finely certain and artificial, as definitely a creation of social tradition, as language or religion or industrial technology.[4]

In these terms living language is much more than words which can be written.

> Language may be defined as an arbitrary system of vocal symbols by means of which human beings, as members of a social group and participants in a culture, interact and communicate . . . Communication is a specialization of symbolic behavior that exists coterminously with culture.[5]

In this frame of reference language includes at least four levels of interaction: (1) lexical: the words which can be written; (2) paralanguage: the matrix in which words are spoken; (3) kinesics: body motion, posture, facies, gestures; (4) visceral: physiological indicators which may act as modifiers of messages at other levels: blushing, blanching, fainting, carotid and temporal artery pulsations, respiratory rate, pupillary size, eye movements, perspiration, salivation, pilomotor erection.[6]

After Pike introduced a method of notation for linguistic and paralanguage features of spoken language in 1942, variations and refinements were added by Smith and Trager, and others. The success of these exploratory efforts encouraged a team of anthropologists (Bateson, Birdwhistell, Hockett and McQuown), and two psychiatrists (Frieda Fromm–Reichmann and Brosin) during 1956–1964 to work on sound films and

tapes of families, particularly one family with one child, two members of which were in psychiatric treatment. The growing insights available to the team members after repeated viewing and reconstruction of various hypotheses seemed to justify the expenditure of an enormous amount of time and energy in making a so-called micro and semimicro examination of small portions of the sound film and tape. This entailed a detailed, precise transcription of all sounds and body motions broken down into their component elements. There are 24 frames per second in the 16 mm. film used. The interview is photographed in the home or office without any artificial lighting. After an initial period of becoming accustomed to the camera, there seems to be minimal interference between the subjects and the interviewer as far as gross comparison with controlled comparisons can be made. This opinion has been reconfirmed by numerous workers in a variety of situations even though all observers are aware that artifacts may be introduced by the cameras and should be watched for constantly.

Other examples of developing techniques are those of Charny, Condon, Loeb, and Sarles at the Department of Psychiatry at the University of Pittsburgh School of Medicine. Charny finds remarkable consonant postural behavior (postural harmony) with the changes in lexical production. These consonant postural phenomena were divided into two groups: mirror image and identical image. At a more macro level, the consonance data whether identical or mirror, supports the hypothesis that they are significant, each in its own way, to the thematic pattern of the interaction as a whole.[7]

Condon demonstrates that linguistic units cannot be divorced from kinesic units, and that aural and visual investigations of the streams of human communication do not constitute separable areas of study. Demonstration of the presence of synchrony sequences at the micro level satisfies the crucial need for definable interactive units in the multilevel, continuous process of information exchange transactions (communication) between two persons. He has defined minimal and higher order movements of body parts (head, eyes, eyebrows, mouth, and fingers) which recur isomorphically with units of speech, thus establishing units which are truly linguistic-kinesic rather than linguistic *and* kinesic. There is a hierarchy from minimal units through syllabic, word, phrasal to larger communicational forms. This can be better done with film at 48 frames (double-speed) and 64 frames per second than the conventional 24. "Self-synchrony" (internal harmony of an individual's communicational behavior) is more clearly seen at 64 frames per second. Condon and Sarles have found synchrony and dissynchrony in the higher primates filmed by Professors Harry Harlow and Eugene Sackett of Wisconsin. Preliminary study in conjunction with W. D. Ogston suggests that such synchrony can also be observed in pulse rate and rhythm and in electroencephalographic patterns. Not only were synchronous wave forms observable, but a phrase, repeated subvocally by one of the two subjects in the interaction, appeared to give an identifiable EEG trace. Because of the technical difficulties this work must be carefully verified.[8]

Loeb and Condon identified 41 units of behavior of a patient talking to a therapist in a 33-minute film at various levels of lexical, linguistic, and kinesic activity. They found that the linguistic and kinesic units tended to occur in specific lexical and/or "meaning class" contexts. Linguistic units, phonemes, morphemes, and larger units of speech were found to begin and end simultaneously (down to 1/24th of a second) with the beginnings and endings of kinesic units. Of several related body movements to be studied in detail, Loeb worked on a gesture, called "S_2," consisting of a specific pattern of movements which resembles a grasping movement. It (S_2) occurs with the words "in," "out," or "off," and in every case with the meaning class "something or someone getting 'off' ('out') away from the patient or her mind," or with the meaning class "someone or something getting 'in' close to her or her mind." This was verified in another film of the same patient in another context, and in another film where a psychiatrist from a different subculture uses the same gesture in the same meaning class. Since the differences in the lexical contexts may be regional or characterological, more comparisons must be done, together with explanations to relate this gesture with various manifestations of the grasp reflex seen in infants, and even in other mammals such as cats and dogs. It may be in humans a signal revealing unconscious activity which has remained remarkably free from modification by experience or ego control.[9]

Sarles, an anthropologist-linguist, in addition to the work cited above, is concerned with obtaining more focused issues and better contrastive data now available with new tools in studying such phenomena as pitch, stress, and tempo. Under specified experimental conditions, using a precisely sound-synchronized film taken at "double-slow motion" (48 frames per second), Sarles finds data that information concerning the shape of the total sentence to come, at least with respect to the number of words, is already established after the first one or two items; that many pitch and stress phenomena seem to be related to the listener's reactions to *contrasts*, and that pitch and stress relationships partially overlap as far as the speaker of English is concerned. The apparent speed (perceived difference) of a speaker may be and often is a matter of the spacing of silences, rather than attributable to differences in terms of larger units such as the phrase or sentence. The use of oscilloscopic micro-techniques for more accurate and systematic observations is proposed to uncover a new body of knowledge concerning language structure.[10]

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IN SEPTEMBER 1945 the remarkable achievements of medicine in the European Theater of operations were related by Doctor Middleton who had just returned from Europe. He lauded the drugs, sulfanilamide and penicillin. Better medical training for the past 25 years has been responsible for much of the success physicians have had in treating casualties of World War II, he said. "A new generation has come up," Col. Middleton said, "knowing how to do a better job and it has done that better job." Most conspicuous contribution to medicine during this second world conflict, he said, has been the great decrease in the instance of disease. Of 3,500,000 men, Doctor Middleton asserted, only 50 had suffered typhoid fever and of these only two had died. There was but a single instance of tetanus, he reported, though the Germans who failed to use preventative methods, suffered hundreds of casualties. "If they had set out to give us a control," Col. Middleton said, "they could not have done a better job."

RESOLUTION

Unanimously adopted by the Council of the State Medical Society of Wisconsin, at its February, 1955 meeting.

William Shainline Middleton, M. D.

WHEREAS, Doctor William Shainline Middleton, will, on March 1, 1955, retire as Dean of the University of Wisconsin Medical School, to become Chief Medical Director of the Veterans Administration, and

WHEREAS, Doctor Middleton, *the Physician*, is a distinguished clinician, one of the most popular and best loved doctors to serve the patients of the University Hospitals, a true servant of humanity, an advocate of the State Medical Society of Wisconsin, to which he contributed so generously through the creation of the Council on Scientific Work and leadership to the Student Loan Fund, and Section on Medical History, and

WHEREAS, Doctor Middleton, *the Dean*, an able administrator and noted authority on blood and cardio vascular disease, has earned the everlasting gratitude of his students, and the people of Wisconsin as the architect of a great medical school, welding the art and science of medicine to the minds of men so that they may be known as physicians, and

WHEREAS, Doctor Middleton, *the Officer*, having already served his country above and beyond the call of duty in two world wars, and taking a leading role in the establishment of an eminently successful program for the care of the Disabled Veterans, now takes up the reins of the world's largest medical administrative position, now therefore be it

Resolved, That Doctor Middleton, *the Man*, beloved by his patients and students, honored by educators and praised by Governments, receive the heartfelt thanks and appreciation of the Council of the State Medical Society of Wisconsin, for his outstanding contributions to medicine and public health in Wisconsin, and its sincerest best wishes for a most successful future.

Investigation of Heart Disease by Catheterization Methods

By GEORGE G. ROWE, M. D., Madison, Wisconsin

WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

■ MEDICAL DIAGNOSIS is a statistical process[1] in which each feature of the patient's history and physical examination is weighed carefully by the clinician. Of necessity, the accuracy of this process depends upon acquisition of a sufficient number of facts. Unfortunately acquisition and verification of such information is frequently difficult and/or time consuming, and therefore there is a perennial tendency to try shortcuts to the diagnosis. In many circles, cardiac catheterization is regarded as such a shortcut. It is the purpose of this article to indicate that such is not the case but that catheterization is merely an extension of clinical cardiovascular examination.

Information derived from cardiac catheterization may be divided into several categories, each of which may assume greater or lesser significance depending upon the patient's disease. In some situations certain features are of so little importance that particular observations may not even be made, whereas in other circumstances information derived from these same observations may be critical. Catheterization may involve recording of pressure and measuring the oxygen content of the blood within the cardiac chambers and the vessels arising from them; utilization of the catheter as a probe to establish the position and relations of normal structures and abnormal passages; acquisition of indicator dilution curves and the study of their morphology; and finally, viewing of the heart in motion as reflected by angiocardiography or cineangiocardiography. Each of these procedures will be elaborated upon further.

Pressure Curves. The application of the strain gauge to intravascular pressure measurement[2] has made it possible to obtain high fidelity recordings through cardiac catheters up to 1.5 meters in length. Such pressure curves may be of significance from many points of view. The absolute level of the pressure may be of great importance. For example, a right atrial mean pressure exceeding 10 mm. Hg. requires explanation. The demonstration of a marked discrepancy in systolic pressure between a ventricle and its outflow vessel is ordinarily explained simply in terms of pathologic anatomy. Thus the severity of valvular stenosis is related mathematically directly to the pressure gradient and indirectly to flow through the orifice. Current techniques of transseptal and retrograde catheterization of the left side of the heart (Fig. 1) have made such observations available in the intact conscious human subject for both the mitral and aortic valves as well as the tricuspid and pulmonic valves (Fig. 2).

Interpretation of the contours of the pressure curves is much more difficult than estimation of the severity of stenosis because of the ever present possibility of artefact, and the unpredictability of volume distensibility curves of diseased cardiac chambers. Although a sharp rise in atrial pressure during ventricular contraction ordinarily indicates incompetence of the atrioventricular valve, brief consideration reveals that the height of this "v" wave (Fig. 3b) cannot be correlated directly with the amount of valvular insufficiency. It will be apparent in considering only one of the variables, that if the volume of the left atrium is 50 ml. and the volume of mitral insufficiency 5 ml. per cardiac systole, the change in left atrial volume approximates 10%. Similarly if the volume of the left atrium is 1,000 ml. and the volume of mitral insufficiency 100 ml. per cardiac cycle, the change in left atrial volume is approximately 10%. Since the rise in pressure within an atrial chamber during

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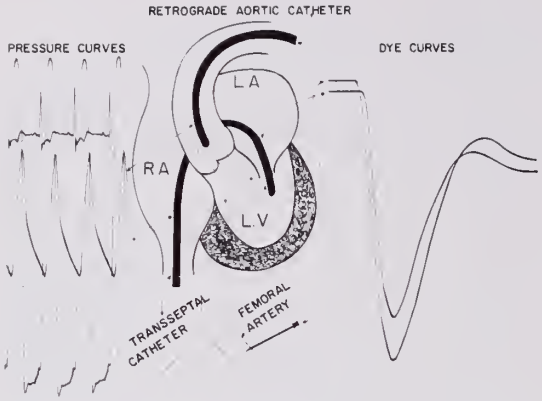


Fig. 1—The diagram indicates how the left-sided cardiac chambers may be explored by cardiac catheterization, and the side panels indicate the type of information which may be obtained from photographs of actual pressure curves and indicator dilution curves. The panel on the left reveals pressure tracings showing aortic stenosis with left ventricular pressure greatly exceeding aortic pressure. The dye curves on the right reveal gross aortic insufficiency by the large amount of dye which appears in the left ventricle after injection into the aorta.

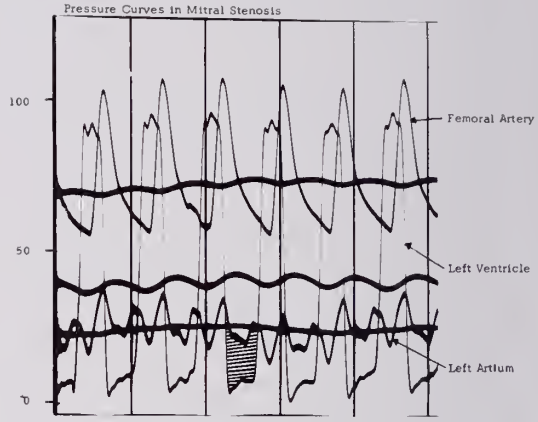
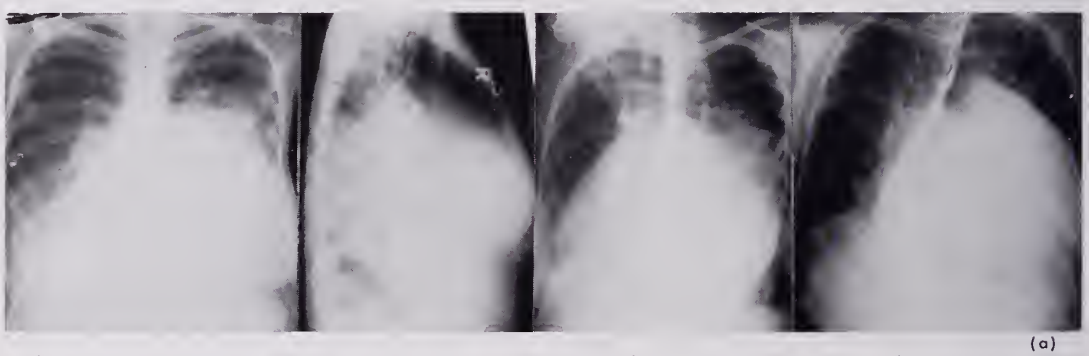


Fig. 2—Pressure curves are shown as recorded simultaneously through catheters attached to strain gauges. The sensitivity of the system has been adjusted so that with each catheter manometer system one mm. of deflection equals one mm. Hg. The pressure gradient from the left atrium to the left ventricle during diastole (shaded on one cycle) is a measure of the severity of mitral stenosis.

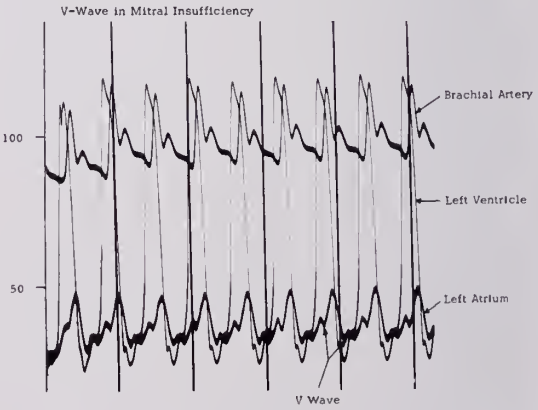


(a)

Fig. 3—(a) The clinical x-ray films of this subject indicate reasonably well her degree of cardiac disability. At operation there was gross mitral insufficiency attributable to hypoplasia of the anterior papillary muscle. (b) the "v" wave is at most 15 mm. Hg. high and does not correlate well with the degree of mitral insufficiency.

regurgitation is a measure of the volume of insufficiency, the normal inflow during systole, and the atrial volume-distensibility curve, there is reason to suspect that the change in pressure recorded in the atria under consideration in the immediately preceding examples might be roughly equivalent. However, since the amount of increased left ventricular work is related to the increase in stroke volume and contingent upon the quantity of insufficiency, it is apparent that the height of the "v" wave may not be directly related to the severity of the lesion. It is not surprising, then, that time and further observation have nullified all of the formulae

(b)



whereby valvular insufficiency is related to the morphologic characteristics of the atrial pressure contours and only a rough degree of qualitative relation is now recognized.

Oximetry. Present day oximeters determine the oxygen content of flowing blood with considerable accuracy,[3] thereby making it possible to determine the oxygen content of blood and return it to the circulation. Since pressure in the chambers of the left side of the heart is generally higher than in the right, septal defects are ordinarily associated with contamination of the right-sided chambers by highly oxygenated blood. Oximetry, therefore, should furnish a measure of the location of such a defect and the quantity of blood flowing across it. Unfortunately many factors are involved in this simple proposition and it, too, becomes complex.

To elaborate on only one of the problems, the highly oxygenated blood which comes into the right atrium through an atrial septal defect may pass so directly into the right ventricle that the oxygenated stream is not detected in the right atrial samples, and the conclusion may be drawn erroneously that the shunt occurs at the ventricular level. Similarly, the presence of highly oxygenated blood in the right atrium does not necessarily indicate that a defect exists in the atrial septum since similar oxygenation may be produced by anomalous pulmonary venous connection, coronary-cameral fistula, ruptured aneurysm of the sinus of Valsalva, left ventricular-right atrial canal, ventricular septal defect with tricuspid insufficiency, rupture of the intracardiac portion of the aorta into the right atrial chamber, and the like (Table 1). Consequently the results of oximetry demand careful interpretation in the light of further information.

TABLE 1— *O_2 Saturations in Fistula from Right Coronary Artery to Right Atrium*

	% Saturation	O_2 Content (ml. 100 ml.)
Superior Vena Cava	69	11.7
Inferior Vena Cava	73	12.4
Right Atrium	82	13.9
Right Ventricle	81	13.7
Pulmonary Artery	80	13.5
Femoral Artery	96	16.2

COMMENT: The increased oxygen saturation in the right atrium is apparent when compared to superior and inferior vena cava specimens. The diagnosis after catheterization (a number of years ago) was atrial septal defect. Actually the patient had a fistula from the right coronary artery to the right atrium.

The Catheter As a Probe. Information may also be derived during cardiac catheterization by utilization of the cardiac catheter as a probe. It is relatively simple to identify the abnormal position of the aorta in transposition of the great vessels when its course is delineated by a cardiac catheter passed through the aortic arch into the left ventricle. Similarly the abnormally medial position of the pulmonary artery in this anomaly may be surely identified. A cardiac catheter passed through the atrial septum helps to differentiate the cephalically placed sinus venosus type defect from the more usual ostium secundum or primum defect. Utilizing oximetry as a guide, anomalous pulmonary veins may be catheterized directly to localize their specific point of connection. The patent ductus arteriosus may be identified with certainty by passage of a cardiac catheter from the left pulmonary artery into the descending aorta (Fig. 4). An aortic window may be similarly identified by passage of a cardiac catheter from the proximal part of the aortic arch into the pulmonary artery or vice versa.

But even as the course of a catheter may clarify certain situations so may it also cause confusion. Direct passage from the right to the left atrium does not necessarily indicate an atrial septal defect since the foramen ovale is anatomically patent in approximately 25 per cent of adults and a progressively higher percentage in younger children and infants. Furthermore, passage of a catheter through a ventricular septal defect and into the aorta is not evidence that the aorta overrides the ventricular septum, since this course may be followed either with or without aortic override.

Fig. 4—A cardiac catheter is shown after it has been passed through a patent ductus arteriosus and down the descending aorta. It should be noted that the point of transit from the pulmonary artery to the aorta is posterior rather than anterior.

Indicator Dilution Curves. Subsequent to injecting an indicator through a cardiac catheter a curve describing its rising and falling concentration may be inscribed from peripheral arterial blood. The morphology of this curve conveys a great deal of information concerning the central circulation. It is possible to detect intracardiac shunts, and define their magnitude and direction;[4] to measure cardiac output, and "central volume,"[4,5] and to obtain a general indication of the presence and severity of valvular insufficiency.[6,7] By utilizing two intracardiac catheters, it is possible to inject indicator downstream (distal) to any of the cardiac valves and sample immediately upstream (proximal) to them (Fig. 1). Thus valvular insufficiency may be measured considerably more accurately than from single indicator dilution curves. Even so, significant errors may occur depending upon whether indicator is injected during systole or diastole, or whether the sampling catheter is in the stream of regurgitated indicator or is turned away into the periphery of the chamber where most of the regurgitated jet is missed (Fig. 5).

Since the concentration gradient of indicator rises very steeply on the leading edge of a centrally injected bolus and falls very slowly during its exponential washout, it follows naturally that right to left shunts are more easily identified in the arterial system than are left to right shunts.[8] If, however, indicator is injected into the distal pulmonary artery or into the left side of the heart, and a second cardiac catheter withdraws blood from the right side of the heart distal to the entry of a left to right shunt, early recirculation of indicator may be identified much more readily and smaller left to right shunts can be localized (Fig. 6). Indeed, by the indicator dilution technique, shunts can be localized which are so small that the defect which permits them can be found only with difficulty during open heart surgery. Similarly, degrees of valvular insufficiency which are of no clinical or hemodynamic significance can be identified (Fig. 7). To make interpretation more difficult, most morphologic alterations in indicator dilution curves can be produced as artefacts. It is clear then that with indicator dilution curves the opportunities for error are legion (Fig. 5) and the potentialities for deriving useful information equally great.

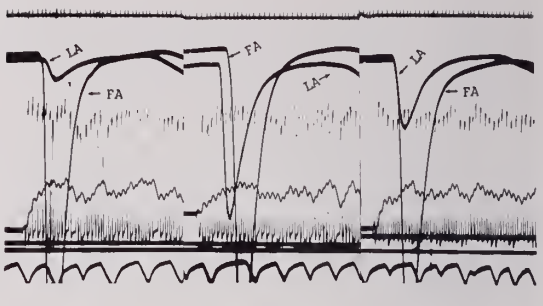


Fig. 5—These "double dye curves" were recorded successively in the same individual during the same catheterization by injecting dye in the left ventricle and sampling simultaneously from the left atrium and the femoral artery. Ordinarily with this procedure the quantity of dye aspirated from the left atrium is roughly related to the amount of mitral insufficiency. There was no reason to believe that the amount of mitral insufficiency changed between the recordings of the curves and therefore the difference is presumed to be random and related to the variation in mixing within the ventricle and atrium with the different phases of the heart cycle. This is an unusual but troublesome result.

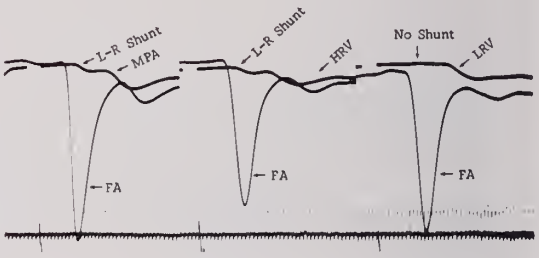


Fig. 6—The two indicator dilution curves were recorded simultaneously, one from blood aspirated from the femoral artery and the other from successively the pulmonary artery, right ventricle and right atrium. It will be seen that in each case the shunt is so small that the dye curve from the femoral artery is normal. The dye curves taken from the right side of the heart leave no doubt, however, that a left to right shunt occurs into the right ventricle. From clinical examination this defect was a small ventricular septal defect, too small to justify surgical repair.

Angiocardiography. A considerable amount of information may be derived concerning the circulation through radiographic exposures taken during the transit of contrast substance.[9,10] These substances may be introduced into the venous system, in the right or left side of the heart, or in specific arterial vessels. Under optimal circumstances angiocardiography makes it possible to identify the position, shape and size of septal defects, the thickness and mobility of cardiac valves, the severity of stenosis or insufficiency, the shape and size of the chambers and the thickness of their walls, as well as the status of the great vessels, and the coronary arteries.[11]

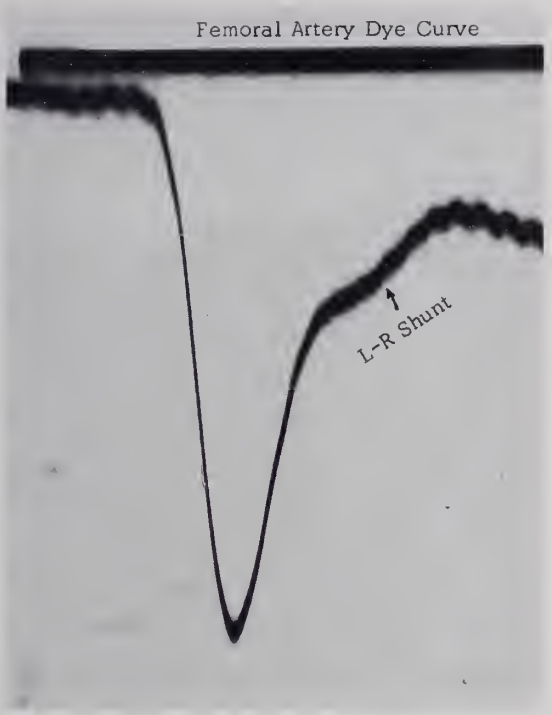


Fig. 7—This indicator dilution curve was recorded from femoral arterial blood and indicates clearcut recirculation of dye from a left to right shunt. Although a leak of bright red blood was found at the time of open heart surgery, the actual septal defect was so small and so well hidden in the trabeculae carneae that it was found only with great difficulty.

Recent developments have made it possible to record pictures at 60 to 120 frames per second and to view them in slow motion and in three dimensions.[12] A study of these pictures has demonstrated unequivocally the inadequacy of intracardiac mixing and the fallacy of many theoretical discussions concerning instantaneous mixing in the circulation. They have also demonstrated that the atrioventricular valves are very frequently incompetent during ventricular premature contractions.[13] Therefore, the presence of ventricular premature contractions in the early inscription of an indicator dilution curve may invalidate its morphologic evidence of valvular insufficiency.

It is unfortunately true that the injection of contrast substance carries with it a greater risk than most other procedures during cardiac catheterizations.[14,15] Furthermore, all contrast materials are toxic to a variable extent, so that the number of injections which can be done safely in any one study is limited.

On more than one occasion valvular insufficiency has been diagnosed erroneously when contrast substance has regurgitated through the atrioventricular valves during ventricular premature contractions or during diastole as a consequence of the high pressure injection. Similarly tricuspid or mitral insufficiency may be diagnosed incorrectly when the cardiac catheter regurgitates from the ventricle into the atrium during the course of injection, distributing the opaque cloud in both chambers. Careful study of films taken at high speed will usually resolve these problems providing the observer is alert to the possibility of error.

Discussion. When diagnostic cardiac catheterization began, it was a relatively simple procedure, but as it has evolved it has become steadily more complex. Presently a diagnostic catheterization may include insertion of one or more catheters into the venous side of the circulation, transseptal or percutaneous catheterization of the left side of the heart, retrograde catheterization of the left ventricle through peripheral arteries, and deliberate cannulation of the coronary arteries for arteriography. Currently, in evaluating multiple valvular disease, right-sided cardiac catheterization is combined with transseptal catheterization of the left atrium and left ventricle, accompanied by retrograde catheterization of the left ventricle from a peripheral artery. Such a procedure carries a risk to the patient of arrhythmias; trauma to the endocardium, valves, or to the myocardium; perforation of the cardiac chambers; formation of intracardiac thrombi with or without embolization; knotting, tangling, or breaking of catheters within the vascular system; and laceration, destruction, or thrombosis of the veins or arteries into which catheters are inserted.[15] Depending upon the selection of cases for this type of study, major complications may occur in 3 to 5 per cent and mortality in 1 per cent or more. These complications would not be acceptable in a diagnostic procedure if the subsequent risks during surgery were not markedly reduced by an accurate preoperative diagnosis.

As the combinations and permutations of procedures which form a necessary part of cardiac catheterization have become more complicated, it has become progressively more important for the individual in charge of such procedures to understand the patient's clinical problem thoroughly when such a study is undertaken. It is neither

practicable nor desirable to do all of the diagnostic procedures which can be done to each subject who undergoes cardiac catheterization. On the other hand a lesion which is not suspected prior to study may well be missed because the appropriate maneuvers are not carried out. The percentage of correct and complete diagnoses is related directly to the skill, knowledge, experience, and vision available in the catheterization team. Furthermore, it should be remembered that catheterizations are done not only for today but also for tomorrow when the terrapin therapy, lagging behind, has passed our current mark. The number of mechanical, electrical, chemical, mathematical, tactical, and human errors which can occur in such a procedure seem to be infinite; hence to reach a diagnosis each of these possible errors must be weighed along with the clinical picture, the history, and the physical examination. It is true that diagnostic cardiac catheterization adds very greatly to the capabilities of the clinician; so do the capabilities of the clinician add greatly to the suitability and completeness of information obtained from catheterization. Although there is a strong tendency in some quarters to look upon cardiac catheterization as a menial task to be done by a glorified technician or a junior physician who is undergoing medical or surgical training, this attitude is to be decried. The full potential of the method is reached in direct proportion to the skill and understanding with which it is performed.

Summary. By gradual evolution cardiac catheterization has become a complicated and time-consuming procedure capable of furnishing a great deal of information concerning the cardiovascular system. Fortunately or unfortunately this evolution has increased rather than decreased the necessity for the procedure to be guided by careful clinical observation. It is unfortunate when cardiac catheterization is undertaken without thorough knowledge of cardiovascular physiology and pathology, and especially without detailed knowledge of the patient's clinical diagnosis.

ACKNOWLEDGMENT: The observations upon which this discussion is based were made chiefly in the wards, operating rooms, conferences, and laboratories of the University of Wisconsin Hospitals and are from the composite experience of many students of all ages who have contributed to the education of the cardiopulmonary team. Unfortunately all of the numerous contributors cannot be listed by name, but I hope many will recognize their contribution. Surely Drs. C. W. Crumpton and W. P. Young must be recognized for their major role in the development of whatever is worthwhile in these concepts.

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MORE OPPORTUNITIES TO STUDY DRUG EFFECTS. Whatever the methodology used and whoever the physicians who wish to participate in the testing of drugs, all of the groups that are concerned—should be vigilant to see that no one steps beyond his qualifications in testing a drug. And they, together with the Association of American Medical Colleges, should see that the problem of studying drugs in humans is placed squarely before medical students and house officers and that more opportunities are provided for them to observe the effects of drugs on people.—HARRY F. DOWLING, M.D., in *J.A.M.A.*, 187: 3 (Jan. 18) 1964.

A Model System for the Study of Growth

By HAROLD P. RUSCH, M.D.
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■ A BETTER understanding of the nature of cancer cells requires, among other things, that we obtain additional information concerning the biochemistry of the steps leading to mitosis. Unfortunately, experiments designed to obtain data on this subject by use of neoplastic cells are complicated by the very nature of the material to be examined. Most cancer tissues are composed of several types of cells and include cells in various stages of the mitotic cycle. To overcome this difficulty, some investigators have devised delicate procedures which yield valuable data from single cells.[1] Other investigators have sought the answers with colonies of cells whose growth cycle could be synchronized[2]; however, such material is often limited in amount and, because of the artificial means required to induce synchrony, may not reflect accurately what occurs under natural conditions. These objections do not apply to the plasmodium of the myxomycete, *Physarum polycephalum*, which is sufficiently large to permit chemical analysis and in which synchronous nuclear divisions occur naturally.

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FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

Because relatively few people are acquainted with this organism, a brief description is in order. The genus Physarum belongs to the class Myxomyceteae, Phylum Myxomycophyta, commonly referred to as the slime molds[3] even though they have no relationship to the common molds. They are more closely related to protozoa and represent a link between protozoa and metazoa. Whereas a metazoan consists of a mass of specialized cells which form a complete organism, the plasmodium of myxomycetes is a large mass of protoplasm containing many nuclei which are not separated by cell walls. Thus, it is an "acellular" organism and becomes cellular only at the very end of its life cycle when uninuclear spores are formed. Small pieces of plasmodia resemble giant, multinucleated amoebae. The myxomycetes are found in many parts of the world, growing on decaying vegetation.

Physarum polycephalum has a complex life cycle (Fig. 1). One of the interesting aspects of this cycle from our viewpoint is the vegetative stage. During this period, the organism is characterized by a large, flat, yellow, disk-shaped, syncytial plasmodium (Fig. 2), whose nuclei divide synchronously even when the organism is as large as 7 cm. in diameter.[4] Thus, the plasmodium may be regarded as a single giant "cell" for some purposes. The plasmodium may form a vegetative sclerotium or undergo sporulation, depending upon the conditions of its environment. Sporulation may be considered a simple form of differentiation, and the conditions for inducing it are now well known.[5] Spores coming to rest in a suitable environment germinate and develop into either flagellated swarm cells or cells resembling amoebae. Two or more of the latter fuse to form a zygote, which then grows to form a plasmodium. The growth of the plasmodium may be accelerated by the fusion of two or more plasmodia.

Because of its novel features, *Physarum polycephalum* is an excellent organism for basic investigations on the biochemistry of mitosis and of differentiation. Studies on both of these processes are in progress in our laboratory, but in this article I will illustrate only a few of the investigations on the biochemical events which lead to mitosis. We are especially interested in the processes which control cell division, inasmuch as cancer cells are characterized by their failure to suppress mitosis.

For experimental purposes we have adapted the growth of the plasmodium to submersed culture in flasks shaken at 170 reciprocations per minute.[6] Under these conditions access to nutrients and oxygen is

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These studies were supported, in part, by Public Health Service Research Grant No. CA-07175 from the National Cancer Institute.

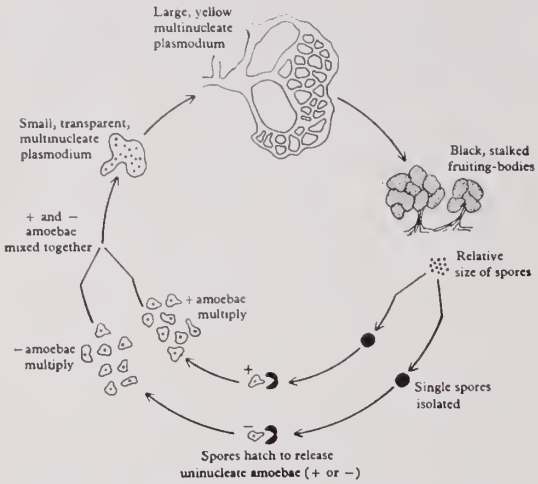

Fig. 1—A diagrammatic depiction of the life cycle of *Physarum polycephalum*. From an article by J. Dee, *Genet. Research, Cambridge* 3:11–23, 1962.

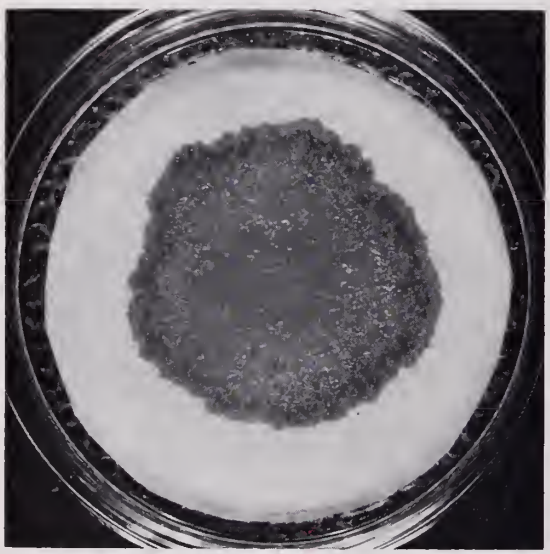

Fig. 2—Two-day-old plasmodium of *Physarum polycephalum* growing on the surface of filter paper supported by glass beads in a Petri dish. Natural size.

ideal, and the growth rate is maximal; however, the rapid shaking fragments the plasmodium into tiny pieces not exceeding 1 mm. in size, which resemble giant multinucleated amoebae. Although mitosis remains synchronous within each piece, there is no synchrony among the different fragments (microplasmodia) in the flask. When the contents of such flask are pipetted onto a piece of filter paper, the microplasmodia fuse into one large plasmodium in about two hours. Fusion is followed by a period of five to six hours during which no mitoses occur; this period corresponds to approximately one-half of the average generation time of the nuclear divisions within the microplasmodia in the submersed culture. After the five or six hours, all nuclei divide synchronously and remain in synchrony with one another through the succeeding divisions until the plasmodium reaches a diameter of 7 cm.[4] Our studies suggest that the synchrony is controlled by cytoplasmic factors. When a large plasmodium from one stage of the growth cycle is allowed to fuse with a small plasmodium from another stage, the time of appearance of the next mitosis is dominated by the larger plasmodium. Such experiments indicate that the factors which control the onset of mitosis increase in amount during the growth cycle and attain a maximum shortly before mitosis.

Another study in our laboratory has been concerned with the relationship of the synthesis of deoxyribonucleic acid (DNA) to mitosis, since DNA carries the heritable information from one generation to the next and plays a key role in regulating mitosis. Howard and Pelc[7] have divided the growth cycle of cells into several periods. The period of DNA synthesis is designated the S period, the postmitotic period preceding DNA synthesis is known as G_1 and the premitotic period following DNA synthesis is G_2. The length of these periods differs in various organisms. In *P. polycephalum* the S period lasts for three hours and immediately follows mitosis,[8] so that there is no G_1 period. Two-thirds of the cycle is devoted to G_2 (Fig. 3); the long G_2 period indicates that DNA synthesis is not the direct trigger for mitosis, as had been assumed by some investigators.

In our studies on the relationship of DNA synthesis to mitosis in *P. polycephalum*, we employed 5-fluoro-2′-deoxyuridine (FUDR)

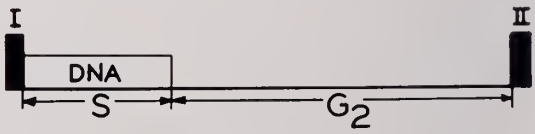

Fig. 3—The black bars represent the periods of mitosis. Period S corresponds to the time of DNA synthesis, and G_2 is the time between the completion of DNA synthesis and the start of the next mitosis.

to inhibit DNA synthesis.[9] Some of the FUDR is degraded to 5-fluorouridine (FUR), which in turn inhibits the synthesis of ribonucleic acid (RNA); to overcome this effect, uridine (UR) was added together with FUDR to overcome the inhibiting action of FUR on RNA synthesis. A typical experiment is illustrated in Figure 4. The solid line marked with triangles indicates DNA synthesis in the control culture. The amount of DNA doubles quickly following mitoses M II and M III. The addition of FUDR plus UR 30 minutes after M II inhibits the synthesis of DNA (solid line, closed circles), but some DNA synthesis does take place and eventually mitosis occurs (M III*), at which time the DNA has reached the control level. Addition of thymidine (Tdr) at the time indicated by the arrow quickly reverses the inhibition of DNA, which soon reaches the control level, and mitosis (M III°) occurs approximately seven hours after the DNA has reached the control level (dashed line, open circles). Note that the G_2 periods in the Tdr reversal experiment and in the control are approximately the same. A similar G_2 period occurs when FUDR and UR are given without Tdr (solid line, closed circles), as was shown by other experiments, but the measurements were not included in this particular experiment. This experiment shows that DNA must be reduplicated before mitosis can occur, and such duplication must be completed at least seven hours prior to the onset of mitosis.

The next step was to determine the relationship of the synthesis of ribonucleic acid (RNA) to the mitotic cycle. A number of investigators have shown that genetic information passes from DNA to RNA by way of messenger RNA (m-RNA). This process is known as transcription. Through a series of steps involving m-RNA, ribosomes, transfer RNA, amino acids, and adequate sources of energy, specific proteins, coded by the m-RNA, are synthesized. Thus the information from the m-RNA is translated into proteins. Some of these proteins are involved in the control of mitosis.

Fortunately it is possible to investigate the role of m-RNA in various biological functions, since its formation can be inhibited by actinomycin D. A number of experiments were performed in which the inhibitor was added to the culture at various times during the growth cycle. Following such addition, the synthesis of total RNA was inhibited

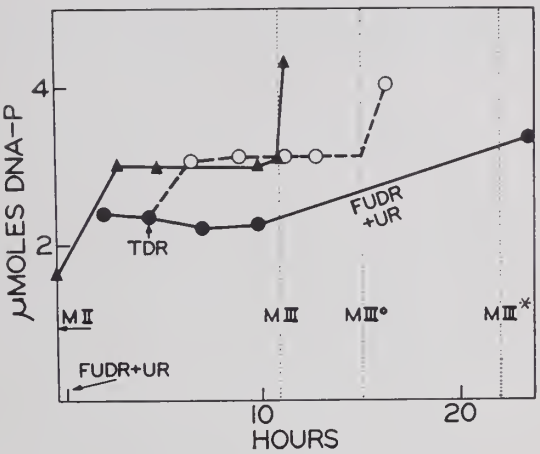

Fig. 4—Inhibition of DNA synthesis by FUDR plus UR and reversal by Tdr—the effect on mitosis. Each point represents the DNA content of a single plasmodium.

M III = Time of mitosis in controls.
M III* = Time of mitosis in cultures in continuous contact with FUDR and UR.
M III° = Time of mitosis in cultures first subjected to FUDR and UR and then reversed with Tdr.
DNA-P = DNA-phosphorus; FUDR = 2×10^{-5} M; UR = 4×10^{-4} M; Tdr = 2×10^{-4} M.

by one-half, but there was no interference with the synthesis of protein or of DNA.[10] The mitosis following the interphase in which the inhibitor was added was not delayed, but the next subsequent mitosis was delayed by about two hours. This result was surprising, since it might be expected that the inhibitor would delay the appearance of the first mitosis following the addition. The results indicate that the m-RNA responsible for the onset of mitosis is formed more than one interphase before that mitosis. They also suggest that m-RNA, which exists for only short periods in bacteria, is more stable in *P. polycephalum*.

In summary, *Physarum polycephalum* is characterized by stages of growth and differentiation which are distinct and separate. Mitosis occurs synchronously, and the plasmodium is sufficiently large to permit chemical analysis without the necessity of applying micro-methods. The usefulness of this organism as a model system for the investigation of the biochemistry of growth and differentiation and for the eventual solution of the cancer problem has been demonstrated.

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Wegener's Granulomatosis

WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

By EINAR R. DANIELS, M. D., Milwaukee, Wisconsin

■ THERE IS A growing literature with an increasing number of reports on Wegener's granulomatosis. However, this is still a relatively uncommon disease. The following case report is of interest because of the absence of the striking upper respiratory involvement usually seen in this disease. It exhibits necrotizing granulomatous lesions of the lung and spleen, disseminated vasculitis, and acute necrotizing glomerulitis with thrombosis.

Case Report. A 70-year-old, white housewife was admitted to the hospital in August 1963 with the chief complaint of "pain in the chest." Three weeks prior to her admission she noted pain of an aching character in the back of the chest near the shoulders which was associated with a low-grade fever. She was given two courses of demethylchlortetracycline (Declomycin) four times daily for four days, but she continued to have her symptoms and a fever which varied between 99 F. and 101 F. These were associated with profound exhaustion, easy fatigability, shortness of breath on slight exertion, and loss of a previously fair appetite. There also was present a productive cough along with mild asthmatic wheezing. The day before her admission her temperature rose to 102 F., the dull aching discomfort in the back of the chest persisted, and rather profound sweating occurred.

The present illness was an extension of a similar episode which began in January 1963 while she was in Arizona and for which she was hospitalized in May 1963 following her return home. The symptoms at this time were chest pains, cough, and wheezing. Consultation with an allergist was obtained, and it was his feeling that we were dealing with an infectious bronchial asthma. Response to conservative management resulted in improvement.

The history of asthma went back over a period of 30 to 40 years and was related to repeated pulmonary infections which usually responded to antibiotic therapy. For several years the patient had been treated for recurring urinary tract infections, although extensive studies of the kidneys at that time failed to reveal any significant pathology. She stated that she had always been a little "anemic." She was also aware of a "lesion" which had been present for many years in the apical portion of the right lung. She had been studied for tuberculosis, and gastric cultures had been reported as negative for acid-fast bacilli. In November 1960 a bronchogram failed to reveal any abnormality. A tuberculin skin test had been reported as "mildly positive." The patient stated that she was never really well and she felt that her chronic illness kept her from leading a vigorous life.

The physical examination at the time of this admission revealed a pale, thin, sick, white woman who was somewhat dyspneic and apprehensive. Her blood pressure was 135/80 mm. Hg.; pulse rate, 94 and regular; temperature, 102 F.; and respiratory rate, 28 per minute. The physical examination failed to reveal any significant pathology of the nasal passages, sinuses, or pharynx. Examination of the chest revealed inspiratory wheezing bilaterally along with diminished excursions bilaterally. Medium and coarse rales were heard over the right apical area. Other positive physical findings included a palpable liver which was felt two finger-breadths below the right costal margin on deep inspiration and was nontender. The edge of the spleen was just palpable. The kidneys were not felt. Costovertebral angle tenderness was present bilaterally. No lymph nodes were palpable. The neurologic examination was considered to be within normal limits.

The laboratory returns included a complete blood count on admission: hemoglobin level 11.1 Gm., hematocrit reading 34.5%, white blood cell count 7,050 per cu. mm. with

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a differential count of 68 segmented cells, 5 stab forms, 12 lymphocytes, 12 monocytes, and 3 eosinophils. The platelets were normal. Sedimentation rate (Wintrobe–Landsberg method) was 31 mm. in one hour. Fasting blood sugar was 102 and a two-hour postprandial blood sugar was 143 mg. per 100 ml. Febrile agglutination tests were negative. Blood serology was nonreactive. Cold agglutinins were positive 1:16. Blood urea nitrogen was 10 mg. per 100 ml. Blood calcium was 4.5 mEq. and the blood phosphorus was 3 mg. per 100 ml. Serum iron was 105 mg. per 100 ml. and the total iron-binding capacity was 230. A cephalin flocculation test was negative in 48 hours. Serum glutamic oxalopyruvic transaminase was 55, and serum glutamic pyruvic transaminase was 79. Fungal skin tests were negative. Sputum examination revealed no tubercle bacilli on concentrated smear. A culture revealed no significant organisms. Examination of the sputum for cancer cells was negative. A urine culture showed no growth in 72 hours. Three blood cultures revealed no growth. Stool culture was negative for pathogens. Normal flora were present. On admission the chest x-ray film showed a cardiothoracic ratio of 12 to 23.5 cm. Apical pleural thickening was present in both apices but was most marked on the right where there was a density present high in the right apical area. The electrocardiogram was interpreted to be within normal limits.

On a conservative program of aminophyllin, oxygen with Alevaire inhalations, and rest, she improved subjectively and had less sweating, dyspnea, and wheezing. This improvement was brief and again her temperature rose to 101.4 F. She experienced more chest pain and began to complain of chills. An x-ray film of the chest taken at this time revealed an extension of the density in the right apical area downward and the appearance of an infiltration in the right lower lobe which was interpreted as being a pneumonitis. The physical findings at this time revealed evidence of consolidation in the apical portion of the right lung. Penicillin therapy was started, but because of the failure to respond it was stopped. She was then treated with tetracycline. However, the fever, sweating, and dyspnea continued, and there was little response to any form of therapy. It was noted at this time that there was a quickening of the pulse and an increase in anorexia along with an increase in the sweating.

The possibility that we were dealing with inspissated bronchial secretions blocking the right upper lobe bronchus arose in view of the presence of the persistent wheezing, shortness of breath, fever, and the failure to

Fig. 1a—Large area of necrotizing granulama of the lung (x150).

Fig. 1b—Note bilateral apical thickening with old fibrotic lesion in right apical area.

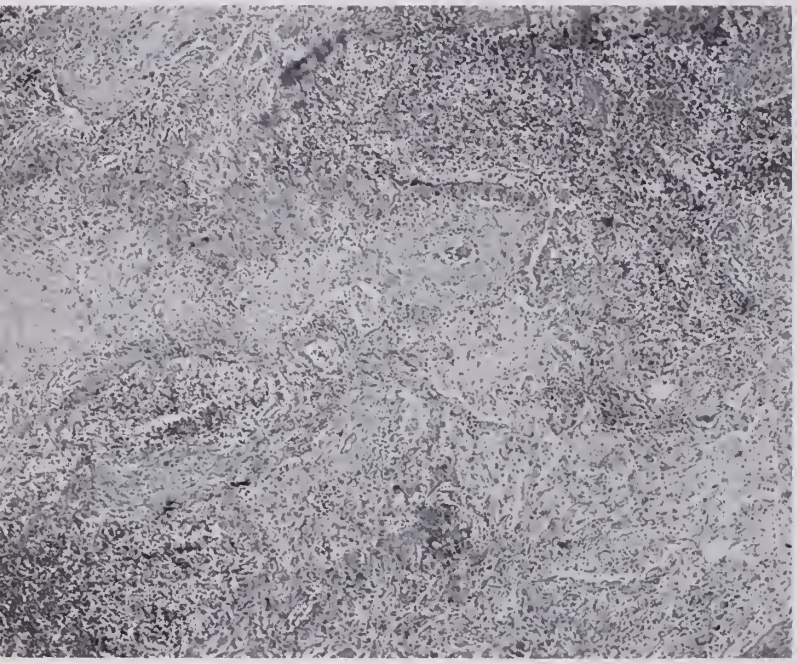

Fig. 2a—Confluent areas of necrosis of the lung. Note organization of intra-alveolar exudate (x150).

Fig. 2b—Increased densities of right upper lobe with more dense and prominent right apical lesion.

respond to any therapy. A course of ACTH given intravenously was begun; and while the response was significant, it did not last. She was then given steroids but continued on a relentless and progressive downhill course.

On an earlier admission the possibility of polyarteritis nodosa had been raised. Now the presence of a vasculitis, a diffuse collagen disease, or a Wegener's granulomatosis were all considered in the differential diagnosis along with lymphoma or carcinoma with metastasis. Because of the patient's downhill course and the possibility of blocked bronchi, bronchoscopy was performed with negative findings. The cough, fever, and weakness persisted. Following bronchoscopy there was evidence of laryngeal irritation and hoarseness which did not respond to simple measures. An otolaryngologist at this time felt that there was a superficial ulceration over the arytenoids with patches of exudate. X-ray examination revealed evidence of an extension of the pulmonary infiltration to the left lung along with the emergence of a Staphylococcus aureus infection which complicated an already complex picture and made management much more difficult. There was no response to treatment, the fever remained high, the patient became more toxic, and died in September 1963, approximately five weeks after admission.

Autopsy findings revealed necrotizing granulomatous lesions of the lungs and spleen along with an acute focal glomerulitis with necrosis; necrotizing vasculitis of the lung, spleen, and kidneys; acute necrotizing ulcerating bronchitis; acute necrotizing ulcerating duodenitis; acute suppurative bronchopneumonia; chronic organizing bronchopneumonia, and a chronic passive congestion of the liver. The entire upper lobe presented as a hard, firm, circumscribed mass with consolidation present in the middle and lower lobes on the right and in the lower one-half of the upper lobe and the upper half of the lower lobe on the left.

Multiple sections of the lungs revealed a profound, diffuse, active, necrotizing granulomatosis. Large areas of lung were completely necrotic. The blood vessels showed considerable thickening of the walls along with intimal proliferation. There was medial hypertrophy with adventitial proliferation and inflammatory infiltrate. In many vessels, particularly the pulmonary veins, there was intraluminal thrombosis. Numerous areas of necrosis were found. Acute pneumonic consolidation was likewise present. Sections of the major bronchi revealed hyperplasia of the surface mucous membrane along with ulceration. The underlying submucosa was

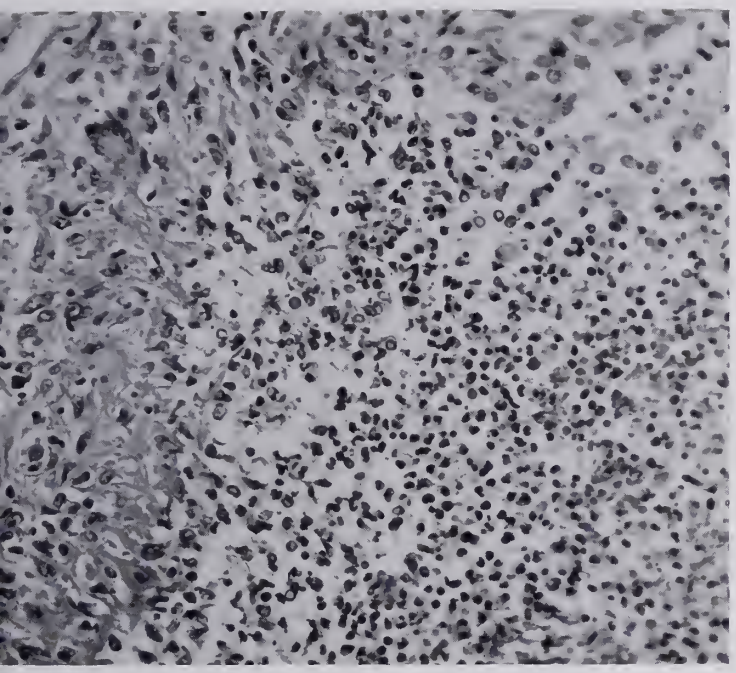

Fig. 3a—Margin of granuloma with epithelioid cells and giant cells of the lung. No caseation present (x150).

Fig. 3b—Extension of infiltration in the right upper lobe with pneumonic involvement of the right lower lobe. Scattered infiltration of the left upper lobe.

diffusely infiltrated by inflammatory cells. Sections of the spleen revealed necrotizing granulomatosis comparable to that found within the lung. The kidneys revealed a well defined, widely scattered and diffuse, necrotizing glomerulitis. Vascular thrombosis was present. Changes varied from fibrinoid necrosis to irregular fragmentation necrosis and intraglomerular thrombosis. Changes within the kidney were primarily at the glomerular capillary level.

Fig. 4a—Fibrinoid necrosis within glomerular tufts of the kidney (x150).

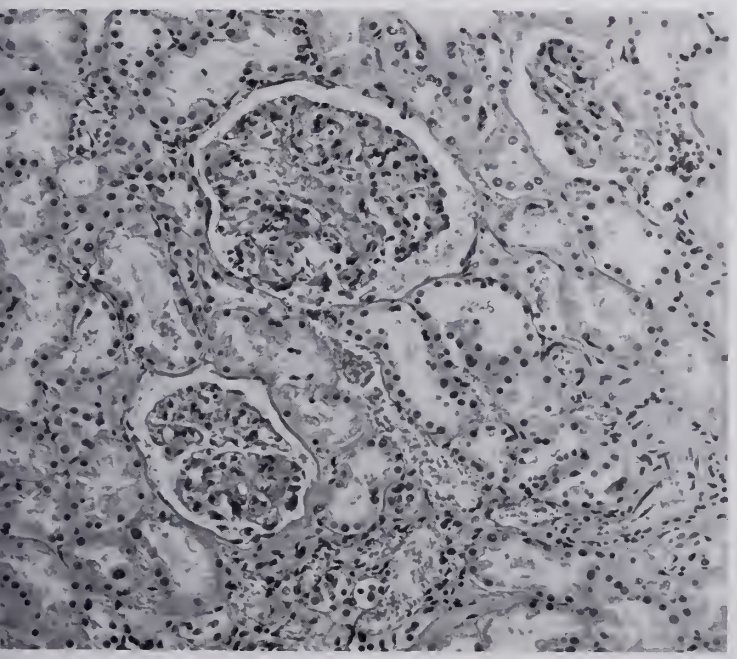

Fig. 4b—Right upper lobe consolidation with bilateral pneumonic infiltration more marked on both sides.

Discussion. This syndrome was first described by Klinger[1] in 1931. Wegener[2] in 1938 described a peculiar "rhinogenous granulomatosis with a special effect upon the arterial system and the kidneys." He felt that the "starting point" of the disease was in the interior of the nose, and as a result of this there was sensitization of other tissues with progressive involvement.

The etiology of this disease remains obscure although some form of altered sensitivity of tissues is accepted most widely as the probable etiologic factor.

The term "pathergic granulomatosis" was introduced by Fienberg[3] and refers to a state of altered reactivity in the tissues, related but not identical to an allergic process. The term "pathergic" was devised by Rössle 30 years ago.[4]

The distinguishing features of Wegener's granulomatosis are the aggressive and relentless necrotizing lesions in the upper or lower respiratory tract, or both, and the associated renal involvement. Godman and Churg[5] in 1954 defined the clinical pathologic criteria which enable one to diagnose Wegener's granulomatosis as an entity. These criteria are: (1) necrotizing granulomatous lesions of the upper air passages or in the lower respiratory tract, or both; (2) generalized, focal, necrotizing, vascular involvement of both arteries and veins; almost always in the lungs and more or less widely disseminated in other sites; and (3) glomerulitis characterized by necrosis (and thrombosis) of loops or lobes of the capillary tuft, capsular adhesions, and evolution as a granulomatous lesion.

However, the one constant finding in all cases is the presence of necrotizing lesions in the respiratory tract. Pulmonary vasculitis is found in practically all cases of Wegener's granulomatosis. The latter is uncommon in polyarteritis nodosa.

It is of interest that Fahey, *et al.*,[6] were responsible for attaching the eponym, Wegener's granulomatosis, to this condition. However, they regarded it as a variation of polyarteritis nodosa. Wegener's granulomatosis has been linked with a number of other conditions. These include Goodpasture's syndrome, Loeffler's syndrome, allergic granulomatosis, polyarteritis nodosa, lethal midline granulomatosis, eosinophilic granuloma, rheumatic arteritis, hypersensitivity angiitis, systemic lupus erythematosus, and Henoch-Schönlein purpura. Whether these are variants of a basic disorder with their own peculiar clinical and pathologic expressions remains for the future to tell. Whatever the relationship between these and Wegener's granulomatosis, the term, Wegener's granulomatosis, should be kept for the present as it spells out a clinical entity with a fairly well delineated pathologic triad.

According to Townley, *et al.*,[7] one should suspect Wegener's granulomatosis in patients with severe persistent sinusitis or pulmonary inflammatory disease of unknown cause, or both, especially if renal damage or vasculitis, or both, accompany or follow the respiratory disease.

Goodpasture's syndrome[8] and Wegener's granulomatosis are similar in that each is initially a respiratory disorder. However, they differ in that in Goodpasture's syndrome the typical lung lesion is a hemorrhage into the lungs which results in a pulmonary siderosis, whereas in Wegener's granulomatosis there are necrotizing granulomatous lesions of the bronchi. The widespread arteritis seen in Wegener's granulomatosis is unusual in Goodpasture's syndrome. However, the glomerular lesions are similar.

The clinical manifestations of Wegener's granulomatosis are protean. This is a febrile illness associated with profound weakness. Symptoms of other systems are dependent upon the degree with which each organ is involved. This disease is relentless in its course and ultimately fatal. The response to any therapy is fleeting. Antibiotics are of no value. There is temporary regression with ACTH and steroid therapy. There is no specific treatment and no known cure.

Summary. This case fulfills the criteria for the diagnosis of Wegener's granulomatosis. All treatment which included antibiotics, ACTH, and steroids was of no avail. There was a notable absence of upper respiratory involvement until very late in the disease. The presence of an unknown pulmonary disease of this order associated with renal disease should raise a suspicion that one is dealing with Wegener's granulomatosis.

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A Review of the Shirodkar Procedure

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WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

■ SINCE THE introduction of the Shirodkar operation into the American literature,[1] the clinical entity of cervical incompetence has gained acceptance in the practice of obstetrics in the United States. Prior to that time only the work of Lash and Lash[2] had focused any attention upon the cervix as a cause of middle trimester abortions in this country. To them goes the major amount of credit for introducing the entity of cervical incompetence to the American medical profession.

However, the Lash operation for the correction of the incompetent cervix never attained any great degree of popularity. Without a more universally adopted procedure for the correction of this clinical problem, most obstetricians remained singularly disinterested in the treatment of middle trimester abortions.

The Shirodkar operation, utilizing a more physiologic approach to this clinical problem, was introduced into the armamentarium of the obstetrician in this country in 1956.[1] With a fairly simple operation having become available more cognizance of the cervical factor in habitual middle trimester abortions was the result. From that time on, the diagnosis and correction of cervical incompetence has been the subject of an increasing number of reports.[3-6] A resumé of the experiences with the Shirodkar operation at The George Washington University Hospital, where the operation was first performed in the United States, is the subject of this report.

Two divergent schools of thought remain at this time concerning both the etiology and the treatment of cervical incompetence. The first group, advocates of Shirodkar, believe that cervical incompetence is due to a physiologic inability of the cervix to contain the enlarging products of conception. They believe that a true anatomic defect is not always found. The second group, headed by Lash, believes that this entity is the result of an anatomic defect in the cervix, secondary to some form of trauma. By the same token there are two principal schools of thought regarding treatment. The first group utilizing the Shirodkar operation advocates closure of the cervix during the 14th to 18th week of gestation. The second group, again headed by Lash, believes that the surgical correction is best done when the patient is not pregnant. The controversy has not been settled to the satisfaction of all, although the Shirodkar operation would seem to be the more popular at this time.

Other surgical procedures introduced subsequently for the relief of this condition have not been as widely accepted.[7,8]

Material and Methods-Results. In this report 108 pregnancies comprise the clinical material. Eighty-eight of the patients had only one pregnancy per surgical procedure. Nine additional patients have had 20 babies. Of those, 7 had 2 pregnancies each following the initial procedure without a repeat Shirodkar-type operation. Thirteen of those 14 infants were viable. Two patients have each had 2 additional living infants following the initial procedure. Both were delivered by Cesarean section 3 times after the primary operation.

Ninety-eight of the patients were operated upon while pregnant. Two nonpregnant patients were operated upon. One of those patients did not succeed in becoming pregnant and the other had an early spontaneous abortion with the only pregnancy which she had following the operation. Analyzing the results of the procedure by the week of gestation in which the operation was performed, it is noted that 20 patients were operated upon before the 14th week. Successful results were obtained in only 12 out of the 20 patients with a fetal salvage of 60 per cent in that group. In the patients operated upon after the 14th week but before the 19th week, a successful pregnancy was the result in 44 out of 54 patients for a success rate of 81.4

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per cent. In the patients operated upon after the 19th week, 17 of 23 patients, or 73.9 per cent, were successful in the outcome of their gestations. Prior to the introduction of the operation, this group of patients had had 440 pregnancies with only 60 surviving infants. The fetal wastage was 89.9 per cent.

Following the Shirodkar procedure fetal salvage for the entire series has been raised to 76 per cent. Eighty-two out of 108 pregnant patients have had surviving infants.

Twenty-three of the infants in this series weighed less than 1500 Gm. In practically all of those the operation had been done prior to the 14th week of gestation. Twenty of those 23 infants died for an extremely poor fetal salvage of only 8.7 per cent. Nineteen infants were delivered who weighed between 1500 and 2500 Gm. Of that group only 2 failed to survive for an overall fetal salvage rate of 89.5 per cent. Fifty-five of the infants delivered weighed over 2500 Gm. Only 3 of that group did not survive for an overall uncorrected fetal salvage rate of 94.6 per cent. Of the 3 infants who died the causes of death were, respectively, hyaline membrane disease, multiple congenital anomalies, and pneumonia.

Since 1957 a Dacron ligature has been employed for the closure of the cervix. Prior to that most of the patients reported in an earlier series had been treated with ligatures of fascia lata,[3] obtained from the thigh of the patient. In about half of the patients in the present series the ligature was removed just prior to delivery or during the puerperium.

Method of Delivery. In 36 of the patients vaginal delivery was the method of choice. Twenty-four of the infants weighed less than 1500 Gm. at the time of birth. Only 2 of those survived. In the 1500-to-2500-gram group in the vaginal series 3 out of the 4 infants survived. When the infant weighed over 2500 Gm. in the vaginal delivery group there were 8 infants, all of whom survived.

The remainder of the patients were delivered by Cesarean section. In all there were 72 such patients. Three patients have had 3 Cesarean sections each. In the less-than-2500-gram group, 14 out of the 15 patients delivered had infants who survived. One infant in the premature group died as the result of the mother having had premature separation of the placenta. In the term infants delivered by Cesarean section, 54 out of the 57 infants survived. The 3 deaths in this group were due to pneumonia, hyaline membrane disease, and multiple anomalies incompatible with life. Of the babies delivered by Cesarean section 68 out of 72 survived for a fetal salvage rate of 94.8 per cent. With correction that figure is 95.9 per cent.

Due to the marked disparity in the number of premature infants in the vaginally delivered group, it is difficult to compare the results of the infants delivered vaginally as opposed to those delivered by Cesarean section. It must be noted, however, that of the babies weighing over 1500 Gm. delivered vaginally, all but one survived.

Comment. An accurate diagnosis of this condition can generally be made from the patient's history or by observing the patient's cervix during the course of a gestation. When a patient has had more than two middle trimester abortions in which pain and/or bleeding have not had a prominent part in the initiation of the abortion, this entity should come to mind. If there has been a sudden rupture of the membranes in the middle trimester of pregnancy followed by an almost immediate loss of the products of conception, cervical incompetence is quite likely. During the course of pregnancy many of the patients who have cervical incompetence will complain of a watery vaginal discharge or of a feeling of pressure in the vagina which is generally the result of prolapsed intact membranes.

Although Mann has done some fascinating work in the radiographic visualization of the cervix to demonstrate its incompetence,[9] that procedure has not been utilized in this fairly large series of patients. In general, one can usually make the diagnosis from the patient's history. There would seem to be no point in doing a radiographic visualization of the cervix in a patient in whom there was no history of repeated middle trimester abortions. Furthermore, even though the radiation dosages involved are small, the use of any x-ray involving the gonads is probably best avoided. It should be reemphasized that the Shirodkar procedure is of no value in other than middle trimester abortions, that cervical incompetence is an uncommon condition, and that the diagnosis should be established clinically beyond reasonable doubt before any surgical procedure is performed for the relief of this condition.

Time of operation. The optimum time to perform the Shirodkar procedure is from the 14th to the 16th week of gestation. The reasons for selecting that particular time are: (1) the patient has gotten safely through the first trimester, (2) the procedure is technically easier to do during pregnancy, (3) amnionitis is invariably present if the cervix has been open for even a relatively short time, and (4) the cervix will not have effaced or dilated by the 14th week to interfere with the technical aspects of the procedure.

When any operation is done upon the cervix during a nonpregnant interval, the possibility always exists that the patient may not succeed subsequently in becoming pregnant. The latter may be due in part to an interference with the "suction reflex" of the uterus as postulated by Israel.[10] Prior to any surgical correction of the cervix patients with cervical incompetence possess an uncommonly high degree of fertility.

Contraindications for the procedure. The contraindications are perhaps more important than are the indications. The procedure should *never* be done in the presence of infection or of ruptured membranes. At least two deaths have occurred in the United States following this type of operation. Both occurred after the operation had been done in the presence of ruptured membranes or with the membranes having been ruptured at the time of the operation. If infection develops following the operation, it is imperative that the closing ligature be removed at once and the uterus emptied. Only in that way may overwhelming sepsis and possibly death be prevented. In general this operation is not particularly effective in the presence of an effaced, dilated cervix. If, when first seen, the patient has an effaced dilated cervix, it is much better to wait for 3 or 4 days to evaluate the irritability of the uterus. In the presence of infection uterine irritability is almost always present. If there is uterine irritability or infection or both, it is imperative that the operation not be done. This operation will produce no miracles. Good judgment as to when it should or should not be performed is far more important than the technical procedure itself.

Technique. The operation is done basically in the same way as illustrated in the original article published in 1958.[3] There have been no significant changes since that time.

Complications. There have been no major operative complications in this entire series. There have been no major problems with bleeding. Blood loss requiring transfusion should be extremely rare. The onset of labor immediately after the operation is uncommon, if there has been no effacement or dilatation of the cervix. The operating time should be between 25 and 40 minutes.

Postoperative Care. In the earlier days of this series the patients were kept in bed for up to 2 weeks following the performance of the operation. However, with the change to a nonabsorbable ligature the patient may become ambulatory as soon as she desires. Most of the patients in this series have been kept on progesterone by mouth or by injection until after the 18th or 20th week. The patient does not have to remain at bedrest, but she should have some restriction of activity during the remainder of her gestation. It is important that she not stand for excessively long periods of time and by the same token she should not undertake long automobile trips. Excessive smoking should be avoided.

Method of Delivery. Most of the patients in this series, as noted from the data, have been delivered by Cesarean section. If the ligature remains covered by the vaginal mucosa, and if the cervix is closed, Cesarean section would appear to be the delivery method of choice. However, it must be recognized that there is an irreducibly greater risk in abdominal over vaginal delivery. The risk can be kept to a minimum by being certain that Cesarean sections are done only in the presence of term infants. In the presence of a previable fetus the ligature should be removed and the patient allowed to deliver vaginally.

One of the reasons for the use of Cesarean section is that it is anticipated that the patient should be able to have more than one pregnancy for each ligature put in place. Obviously that advantage is lost if the ligature has to be removed for vaginal delivery.

If the patient goes into labor with the ligature in place, it must be emphasized that the patient has a totally obstructed labor and rupture of the uterus may result. The patient should be advised to report to her physician immediately if she goes into labor at any time after the performance of the operation.

All of the patients delivered by Cesarean section in this group were delivered by low cervical type.

Fate of Ligature. If the ligature remains completely covered by the vaginal mucosa during the postpartum state and if the patient is having no unusual amount of vaginal discharge, there is no specific reason for its removal. However, if any granulation tissue is noted on the mucosal surface of the cervix, it signifies that the patient has a sinus tract extending downward to the ligature. Invariably this means that the patient has an infected foreign body in her cervix and without question the ligature should be removed. There is no way in which the vaginal mucosa will remain as a covering over the ligature in the presence of infection. No difficulty has been encountered in removing any of the Dacron ligatures.

Subsequent Pregnancies. If the ligature remains in place following an abdominal delivery, there is no reason why the patient may not have more than one gestation with one primary operation. If the ligature has been removed when the patient becomes pregnant again, the Shirodkar procedure should be repeated at the 14th to 16th week of her next gestation. In the two patients in whom the operation was not redone, cervical incompetence was manifested in subsequent gestations. The scar tissue which had formed apparently was not capable of containing the enlarging products of conception.

Conclusions. The Shirodkar operation would seem at this time to be the best method of dealing with cervical incompetence. The operation is best done during the 14th to 16th weeks of gestation. The operation should never be performed in the presence of infection or ruptured membranes. The operation should never be done unless the diagnosis has been clearly established from a clinical standpoint. The ligature must be removed immediately if intrauterine sepsis develops following the procedure. When properly done, however, the likelihood of infection is extremely slight.

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Living Anatomy

WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

By F. A. HELLEBRANDT, M.D., Athens, Ohio

■ I BEGAN MY professional career as a student assistant to the distinguished American anatomist, Charles Bardeen. In the leisurely and more contemplative days of the early 1920's it was the Dean of the School of Medicine who taught the course in Anatomy especially designed to meet the needs of the student of physical education. It followed as a matter of course at the University of Wisconsin, incredible as it seems today, that all of the medical sciences in the physical education curriculum were taught by senior faculty members of the Medical School, usually the Department Head.

It was inevitable that those of us who had the privilege of ingesting Wisconsin's intellectual feast of the early 1920's subsequently approached physical education with a strong biological bias. I myself never ceased being interested in the physiological aspects of exercise and motor learning. Indeed, at the end of a career in Physiology and Physical Medicine, I have come back full circle, to establish a Motor Learning Research Laboratory that has one leg in the Department of Physical Education at Lathrop Hall, and the other in the Bardeen Laboratories of the School of Medicine.

In the 1920's we were concerned overwhelmingly with the memorization of what individual muscles were purported to do because of their mechanical relationships to the axes of the joint or joints crossed. The attack on the study of movement was wholly mechanistic. This was true of kinesiology as well as anatomy. The movements comprising gymnastic maneuvers, and to a lesser degree sport skills, were described in anatomical terms and lists were then compiled of the individual muscles which ought to contribute to the production of the joint positions assumed. This was a highly artificial kinesiology, based almost entirely on synthetic reasoning.

Many years elapsed before I realized fully that muscles do not normally act individually; that the concurrent action of two or more muscles affecting a single joint must modify the contribution of each, yielding a new synergy and not one composed of the sum of its parts; that what a muscle ought to do when examined by itself in the cadaver, is not, therefore, necessarily what it does do in the living. If we wished to penetrate the secrets of man's remarkable capacity to execute complex movements with effortless grace, direct observation on the living would have to take the place of inferences arrived at from cadaver dissection.

Those distinguished professors who taught us biological sciences at Wisconsin in the 1920's were without exception versed in the historical background of their respective fields. Thus, we acquired perspective and humility, qualities necessary to anyone who aspires to contribute to the mainstream of progress in his own field of endeavor. We were taught also how to think, to question, to reason, to seek the truth, and in so doing to go back always to the beginnings of things. And so, at the end of my professional career I propose to take such a backward look at a subject, Living Anatomy, which has grown suddenly exciting because of mid-twentieth century advances in instrumentation subserving biological research. The

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From the Motor Learning Research Laboratory, Department of Anatomy, and the Department of Physical Education for Women, University of Wisconsin. Adapted from a paper read by Doctor Hellebrandt at the Final General Session of the Midwest Association for Health, Physical Education, and Recreation Convention, April 9, 1963.

Supported in part by the Easter Seal Research Foundation, National Society for Crippled Children and Adults, and from a General Research Support Grant to the University of Wisconsin Medical School from the National Institutes of Health, Division of Research Facilities and Resources, Bethesda, Md.

The counsel and support of Dr. Otto A. Mortensen, Chairman of the Department of Anatomy, is gratefully acknowledged; as well as the assistance of Joan C. Waterland, Ph.D., Sallie Ruth Ekern, M.A., and Nancy Munson, B.S., for their assistance in the conduct of the experiment.

Living Anatomy of today is, in effect, Electromyographic Kinesiology. Its techniques have developed sufficiently to put them within reach of every student of movement.

The giants in the anatomic study of movement are Winslow, Duchenne, Beevor, and Wright. Each leaned on his predecessors. Each left a written record considered to be a classic. The foundation was laid by the celebrated 18th century anatomist, Winslow. His major work was published in France in 1732. For a century it ranked as the leading text book of Human Anatomy. Winslow included in it only what he himself had verified during ". . . a very long course of anatomical inquiries . . ." (29:xvii). He was 63 when the text was published. It represents 30 years of full time observation, for although Winslow was Professor of Physick, Anatomy and Surgery in the University of Paris, he was not a clinician.

Muscles do not work alone, Winslow concluded. ". . . where several muscles are fixed to any movable part, they are all in a state of contraction, in every motion of that part; but they are not all in the same degree of action, because the principal movers act more than the moderators. . . . This cooperation of muscles is easily perceived by touching them when the part they belong to is moved with a considerable force" (29: Vol. I, 160). Winslow was aware, therefore, of what we now call the patterning of movement. He introduced the terms principal movers, moderators, and directors in support of this idea. He recognized, also, that gravitational stresses might silence the natural co-contraction of antagonists. Today we possess the instruments needed to verify objectively evidence attained by simple inspection and palpation on living subjects, an art long since forgotten.

The sections in Winslow titled, "The General Doctrine of Muscles," and "The Particular Uses of Muscles . . .," are in essence a compendium of kinesiology. They are as fresh and provocative today as when they were written more than two centuries ago.

The second of the classics on muscular movement was written by Duchenne in 1867. It did not appear in English translation until 1959. The translator calls it an untapped reservoir of important anatomical information. Duchenne lived when Winslow's System of Anatomy was still in use. He knew it well, and used it as the starting point for many of his own observations. Duchenne refers often to his Parisian predecessor in the study of movement as "the admirable Winslow."

Duchenne analyzed normal and pathological movement by electrical stimulation. He understood the limitations of this method. In his hands, electrical stimulation was tantamount to dissecting the living body. But Duchenne was interested in more than a revelation of what individual muscles could do because of the nature of their attachments. He was concerned also with the ways in which action was modified by other members of a functional group. Like Winslow, Duchenne concluded that the isolated action of muscles is a theoretical abstraction. He believed that the co-contraction of antagonists provides the living machine with a perfect device for the delicate modulation of movement. "Without this . . . entente of the antagonist muscles, motions inevitably lose their precision and assurance" (11:552), said Duchenne, and in this we concur.

Duchenne pursued the study of motion by electrical stimulation for nearly 40 years with a single-minded constancy. He lived during a brilliant period of French Neurology and was associated in the Neurological Clinics of Paris with some of the greatest physicians of his day. He was a prodigious worker and a most accurate observer. We who study the written record left by this investigator are his grateful beneficiaries.

The third classic consists of Beevor's *Croonian Lectures on Muscular Movements* (6). Delivered before the Royal Society of Physicians of London in 1903, they were considered important enough to be reprinted in the early 1950's. Although now out of print, they continue to be cited in the current neurological literature. Beevor appears to have studied Duchenne's work exhaustively, and in his Croonian Lectures leans also on the 4th edition of the English translation of Winslow.

Beevor used the same physiological or natural approach to the study of movement adopted by Winslow, that of inspection and palpation. Like Duchenne, he was a clinical neurologist. He became a Fellow of the Royal College of Physicians in 1888. Delivery of the Croonian Lectures gave him the opportunity of collecting the results of 20 years of research, partly clinical and partly experimental. In his Foreword to the reprint of the Croonian Lectures published by *Brain*,

Walshe remarks that neither the clinical neurologist nor the experimental physiologist can afford to overlook the remarkable contributions of this astute observer, and I dare say the kinesiologist might be added. We, ourselves, are engaged currently in the illuminating task of compiling an electromyographic atlas to illustrate the principles enunciated by Beevor out of his contemplation of the writings of Winslow and Duchenne, and his own first hand observations of what muscles actually do when put into action volitionally.

Wilhelmine Wright's *Muscle Function* was reprinted in 1962. The original, published more than 30 years ago, would never have been written if Wilhelmine Wright had not discovered Beevor's Croonian Lectures at a critical point of her own career. In 1916 she happened to pick up a small volume that had stood disregarded on her bookshelves. It was a copy of Beevor's *Croonian Lectures on Muscular Movements* (6), made meaningful because polio had struck in America for the first time in epidemic proportions, and Wilhelmine Wright had been placed in charge of Lovett's therapeutic exercise gymnasium. The endless combinations of paralyzed and normal muscles affecting movements seen in Lovett's clinics provided this perceptive individual with a perfect laboratory in which to study muscle function. She observed, compared, and questioned. Unable to verify on the living what authoritative anatomical sources said about muscle function, she had the audacity to ask who was right, Nature, or Gray's Anatomy. "I watched," she said, "with the patience of a cat before a mousehole; and now and then, perhaps once in a year or once in two years, an explanation of one of my puzzles would show its head cautiously and I would pounce upon it in joyous excitement" (30:xx).

The Croonian Lectures struck Wilhelmine Wright as a revelation of common sense. She decided, therefore, to try to do for the lower extremities what Beevor had done for the upper. Twelve years later, in 1928, she published the results of her own observations. Ever since then her book has been a standard text in the training of physical therapists for the difficult and exacting techniques of muscle re-education. Its applicability to the techniques of motor learning in the normal also warrants study.

A single phrase in the Preface of the original monograph, *Muscle Function*, remained with me throughout my own career as an educator. Wilhelmine Wright thanks Lovett because "he had the generosity of mind to encourage original thinking by his subordinates" (30:xxii). In a different milieu, a questing mind might have been silenced. *Muscle Function* belongs, in a sense, as much to Lovett as it does to Wilhelmine Wright. It leans on Beevor in the same way that Beevor built his concepts on the observations of Duchenne, and Duchenne upon those of Winslow.

As a group, Winslow, Duchenne, Beevor, and Wright forged a strong, direct chain of influence spanning 230 years. Their message rings out "loud and clear." The action of muscles can only be studied in the living. This is the concept of lasting value they handed down one to the other, and also to us. Few things are more difficult to study than human movement. This calls for a quality of mind related, I think, to the kinesthetic acuity of the observer. It is one thing to perceive what the eye sees, another to feel the movement seen. I like to think that Winslow, Duchenne, Beevor, and Wright were so gifted.

From time to time a new method, electromyography in this instance, forces the investigator to reexamination of the validity of traditional approaches to his subject matter. A kinesiology steeped in inferences based on classical descriptive anatomy can no longer be justified. We shall have to listen to what Winslow, Duchenne, Beevor, and Wright have been trying to tell us, and what the neurophysiologist of the mid-twentieth century knows about the mechanisms responsible for the phenomena observed by them with such discerning brilliance.

I should like next to define muscular movement in more physiological terms, using for this purpose an illustration (Fig. 1) redrawn by Jung and Hassler from an unpublished motion picture made by Hess (22:904). Every volitional movement is composed of two parts, that which is willed or cortically controlled, and that which is evoked spontaneously in association with the purposive act and cannot be introspected. Many years ago Kinnier Wilson had said that a very large part of every "voluntary" movement is both "involuntary" and outside consciousness.

In this model the purposive act consists of one man jumping from the shoulders of another and landing upright on the floor. Three

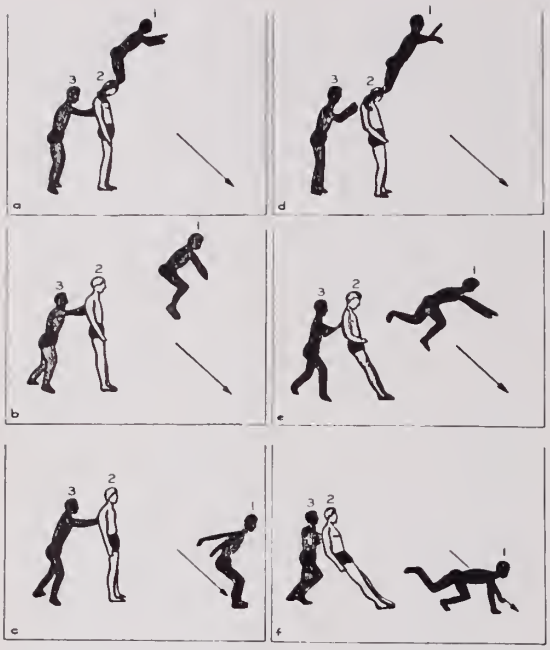


Fig. 1—W. R. Hess' (1943) model of the voluntary and involuntary components of willed movement. Figure 1 symbolizes the prime movers activated by cortical mechanisms. Figures 2 and 3 represent reflexes evoked spontaneously to give postural support to the purposive act and compensate for the recoil. The leaper succeeds only if the carrier and his supporter respond appropriately.

persons represent the action and reaction inherent in the execution of any motor performance. The leaper symbolizes the intentional teleokinetic mechanisms, or the cortical aspect of volitional movement. The leap succeeds only when the right postural set is provided by the carrier in anticipatory readiness for the jump, and when the carrier himself is aided by the supporter who compensates for the rebound. This is illustrated in the row of figures on the left (Fig. 1). The carrier and the supporter symbolize the involuntary aspects of the act. In the figures on the right the carrier is unprepared for the recoil of the leap and falls backward. He is caught by the emergency action of the supporter. The leaper's jump is short and he falls for want of proper postural support at the take-off, and because the reflex regulation comes too late to compensate for the recoil.

In our electromyographic study of movement we are not interested in the behavior of the jumper alone, that is, in the prime movers activated by the will. We are just as interested in the activity evoked reflexly in the antagonists which may be called upon to exert a modulating tension, the synergists, which may neutralize some unwanted action of a muscle which has the capacity to perform more movements than one, and the fixators, which may be needed to stabilize contiguous joints or more remote parts. It is this galaxy of muscular contractions which comprises the so-called patterning of movement. Critchley called this a harmony of which the prime movers constitute the melody. Its components are integrated on various levels in the central nervous system.

Reasoning from first principles suggests that pattern elaboration should be similar in all normal human beings. We are all built on the same model, bipedal, with prehensile upper extremities, in the interests of which we assume an orthograde stance. We are all equipped with a finite repertory of natural movements, fired by the activation of built-in patterns of excitation that result from two billion years of successful movement experience, quadrupedal in its ancestry. Thus, stereotypy in the behavioral response of man is what the observer of movement should anticipate. In our experience, muscles simply do not contract indiscriminately.

The view presented differs from the one expressed by Basmajian in his new monograph, *Muscles Alive—Their Functions Revealed by Electromyography*. He concludes, for example, that the time-sequence of activity in the muscle groups implicated in a movement of the elbow joint is completely random. There is no set pattern. Any of the muscles destined to show activity fires first or last in a wholly unpredictable fashion.

How can we resolve such divergence in opinion? The views are antithetic. A plausible answer is suggested in Beevor's method of studying movement. He defined it as follows: A living person is told to perform a definite movement, and it is then observed which muscles take part in the movement (6). The key words are "a definite movement." I need not tell an audience composed of physical educators that controls must be introduced to insure the proper execution of the purposive act under study. This is expedited when subjects are drawn from a universe composed of individuals capable of movement localization, an ability considerably less simple than it seems at first glance. This is the crux of the whole problem of variability in electromyographic kinesiology. Constancy of electromyographic patterning demands constancy of performance. We must

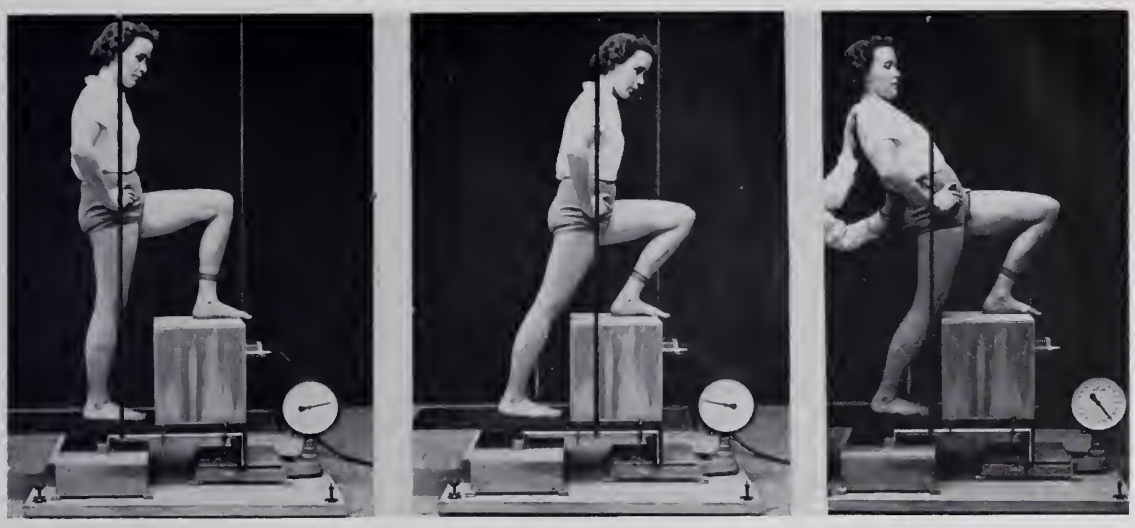


Fig. 2—Subject J.C.W. attempting to produce the center of gravity shifts stipulated by Beevor. She inclines forward and then backward while standing on a C. of G. platform. The vertical projection of the C. of G. has been introduced into each photograph. The white line is a plumb hanging in front of the backdrop.

be reasonably certain that the electromyograms we accumulate really reflect variability in the functional organization of the central nervous system, if this is what we conclude, and not differing degrees of precision in physical performance. The point is an important one which warrants emphasis and elaboration. I can do this by narrating an experiment performed by my group in December of 1962.

You will recall that we have been applying the modern techniques of electromyography to confirm or refute hypotheses proposed by the pioneering advocates of living anatomy, and supported largely by subjective evidence derived from inspection and palpation. One of the last papers published by Beevor appeared in the *Journal of the American Medical Association.* Beevor had been invited to come from England to address the Section on Nervous and Mental Diseases of the A.M.A. at its 59th Annual Session, held in Chicago in 1908. In this paper Beevor describes an experiment designed to demonstrate two principles: *First,* that one part of an anatomical muscle can contribute to a movement without involving the remainder; *Second,* that in every volitional act the prime movers contract in a regular orderly sequence. The muscles successively come into action, adding to their number according to the amount of work that is required to be done. The individual performing the movement has no power to change the order in which the prime movers are mobilized.

The muscles to be studied were the sartorious and the rectus femoris. These are hip flexors. If the thigh is fixed, they flex the trunk on the supporting extremity. The person should stand on one leg, said Beevor, while the other leg rests on a chair, with the knee and thigh flexed. The person should incline slightly forward so as to bring the center of gravity in front of the foot on which he is standing, and then incline backward, so that the center of gravity will shift behind the foot. The latter is impossible, for the subject would fall to the ground, and the former can be achieved only if the "forward inclination" permits flexion of the leg on the foot. Biomechanical terms are often used loosely by the clinician. In Figure 2, the subject (J.C.W.) is trying out Beevor's procedure while standing on a center of gravity platform. A neuromuscularly skilled, well informed and cooperative subject is implementing Beevor's orders as literally as possible, i.e., she is attempting to produce the center of gravity changes stipulated. She had been trained to rid herself of cortical interference when acting as an experimental subject, and to yield without resistance to the natural flow of spontaneous motor reactions. In this way we hoped to reveal how "the wisdom of the body" operates when free of direction by the highest levels of integration.

What happened to the muscles sampled electromyographically is illustrated in Figures 3 and 4. As the subject inclined backward, the soleus of the supporting leg sud-

denly reduced its activity and the tibialis anticus jumped into action (Fig. 3). This is a beautifully coordinated pair of responses. It is a protective reaction, designed to keep the center of weight as close as possible to the middle of the supporting base. Two opposing forces act simultaneously at the ankle joint. When the subject leans back beyond some critical point the soleus is inhibited and the tension exerted by the tibialis anticus is augmented. The living machine resists every tendency of the center of gravity to approach the axis of rotation of the ankle joint, let alone "shift behind the foot," which is what Beevor had ordered. But he was not concerned with the behavior of the supporting limb. Beevor was interested only in the nonsupporting leg, the one placed on the chair. The flexors of the hip on that side were supposed to contract to prevent the trunk from falling backward, the sartorius first, and if the subject continued to incline backward, then the rectus femoris, but without the vasti. Could we confirm this order of succession electromyographically?

Our initial attempts to perform the Beevor experiment were failures. They looked like Figure 4. Every muscle sampled electromyographically was summoned to activity. Furthermore, the subject could not remain sufficiently poised in the posture assumed to grade the degree of inclination. She simply fell backward into the arms of observer N.M. Her concept of Beevor's experimental procedure, derived from a literal interpretation of his instructions, was incapable of demonstrating either temporal sequencing in the response of the hip flexors, or clear-cut fractionation in the activity of the quadriceps.

A systematic effort was made to realign Beevor's procedure to meet his theoretical objectives. We knew what was necessary to achieve this. The subject performed the strenuous Beevor maneuver, and we recorded it electromyographically and/or photographically, in whole or in part, more than fifty times before the results expected were evoked in pure form. It took the greater part of one day to do this. To make a long story short, it was not until one of the observers, a graduate research assistant (S.R.E.), positioned a mirror to permit the addition of visual clues to proprioception, that the dilemma was resolved.

Learning was instantaneous. In a flash of insight the supporting limb was fixed in a near vertical position, the pelvic girdle was stabilized, and the so-called "forward and backward inclination" of Beevor was restricted to trunk bending. The initial trial was a success, indeed, a perfect experiment (Fig. 5). The sartorious *did* spring into action appreciably ahead of the rectus femoris. The rectus femoris *did* contract without evoking significant activity in the vasti. Gravity substituted for the soleus of the supporting leg and the tibialis anticus equilibrated the influence of backward displacement of the trunk on the center of gravity of the body as a whole.

Fig. 3—Change in the EMG response of the soleus and tibialis anticus of the supporting leg as the body inclines backward. No record is being made of action potentials evoked in the muscle groups of the opposite leg.

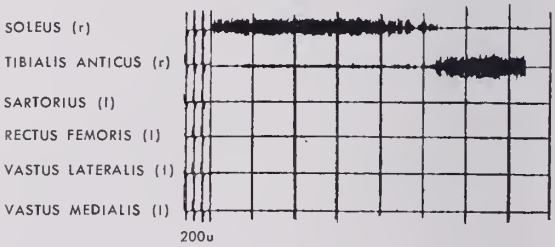
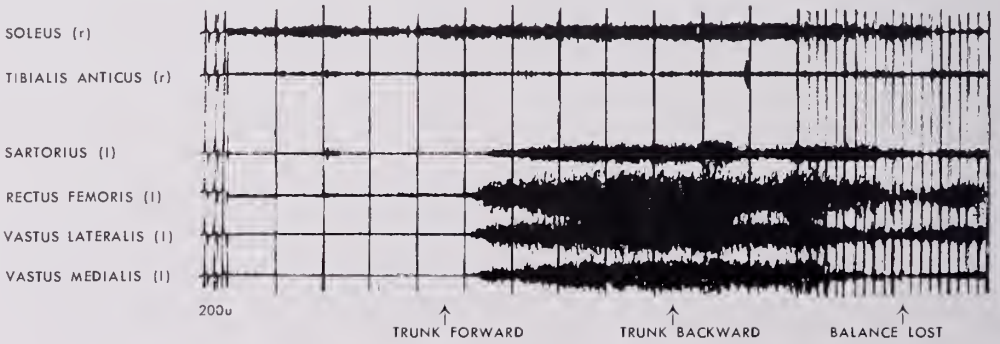


Fig. 4—A failure of the Beevor experiment when the maneuver was performed in the manner illustrated in Figure 2.



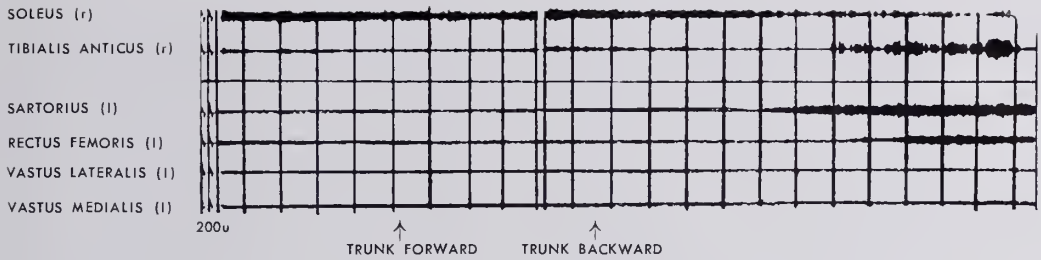


Fig. 5—A successful experiment performed spontaneously when visual cues were added to proprioception. The serial photographs in Figure 7 were taken while this EMG was being recorded.

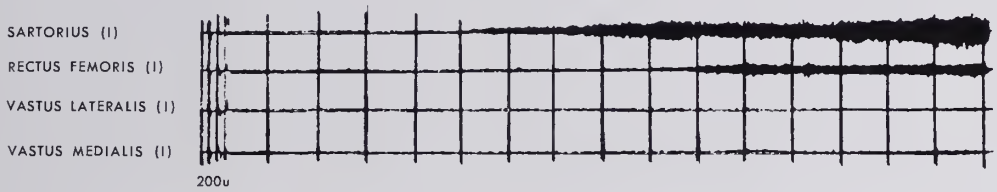


Fig. 6—Confirmation of Beevor's sequential response of the hip flexors and fractionation of quadriceps action evoked by graded gravitational stress.

We could now reproduce Beevor's experiment at will (Fig. 6). The observations were no longer in conflict with his findings arrived at through inspection and palpation. They confirmed his deductions unequivocally. Sequential patterning and fractionation of muscle action did occur when a "definite movement" was executed in a definite way. Had we performed this experiment once on each of 50 untrained normal individuals, selected randomly, our conclusions would hardly have been the same, especially if attention had been focused on the quantification of electromyographic responses rendered unpredictable for want of the requisite skill on the part of the subjects of the investigation. The virtue of experimentation of the type illustrated resides in its ability to illuminate for the student of motor behavior, some facet of central nervous system organization operative in the acquisition of a specific skill. With this thought in mind I should like, finally, to present our interpretation of the instructive Beevor experiment.

1. It is a curious and interesting fact that there was little trial and error variance in the arduous succession of attempts which preceded the proper execution of the "definite movement" ordered by Beevor. A cooperative subject, trained in the art of functional decortication, simply gave in to the automatic running of archaic movement patterns. There are variable degrees of voluntariness, and this subject was intent on keeping cortical activity down to the minimum. The resultant kinetic melody was composed almost wholly of the innate component of motility. It was as "involuntary" as "voluntary" movement could be and still carry out a specific order.

2. Every time the body inclined forward or backward, the effect on the center of gravity was compensated for by automatic reverse movements on the part of other segments of the multijointed whole. Such readjustments are obligatory in the mindless subject. They are stereotypes embedded in the heritage of a bipedal species which stands normally in an unstable equilibrium with a high center of gravity poised precariously over a relatively small supporting base. The subject's responses were subcortically driven. She had no real awareness of what she was doing. No admonitions offered, and these were persuasive, could remodel behavior as long as the subject remained functionally decorticated. "Correcting the movements carried out by our proprioceptive reflexes is something like trying to reset a machine, whose works are intangible, and the net output all we know of the running" (24:89).

Involuntary movement experiences of the type being described, in which an order is issued and the machine then runs automatically, are cloaked in a vagueness which gives them a dreamlike quality. Herrigel, in his engaging discussion of *Zen in the Art of Archery*, defines this as an exquisite state of unconcerned immersion in oneself (21).

3. The driving force that triggered the "definite movement" which had caught Beev-

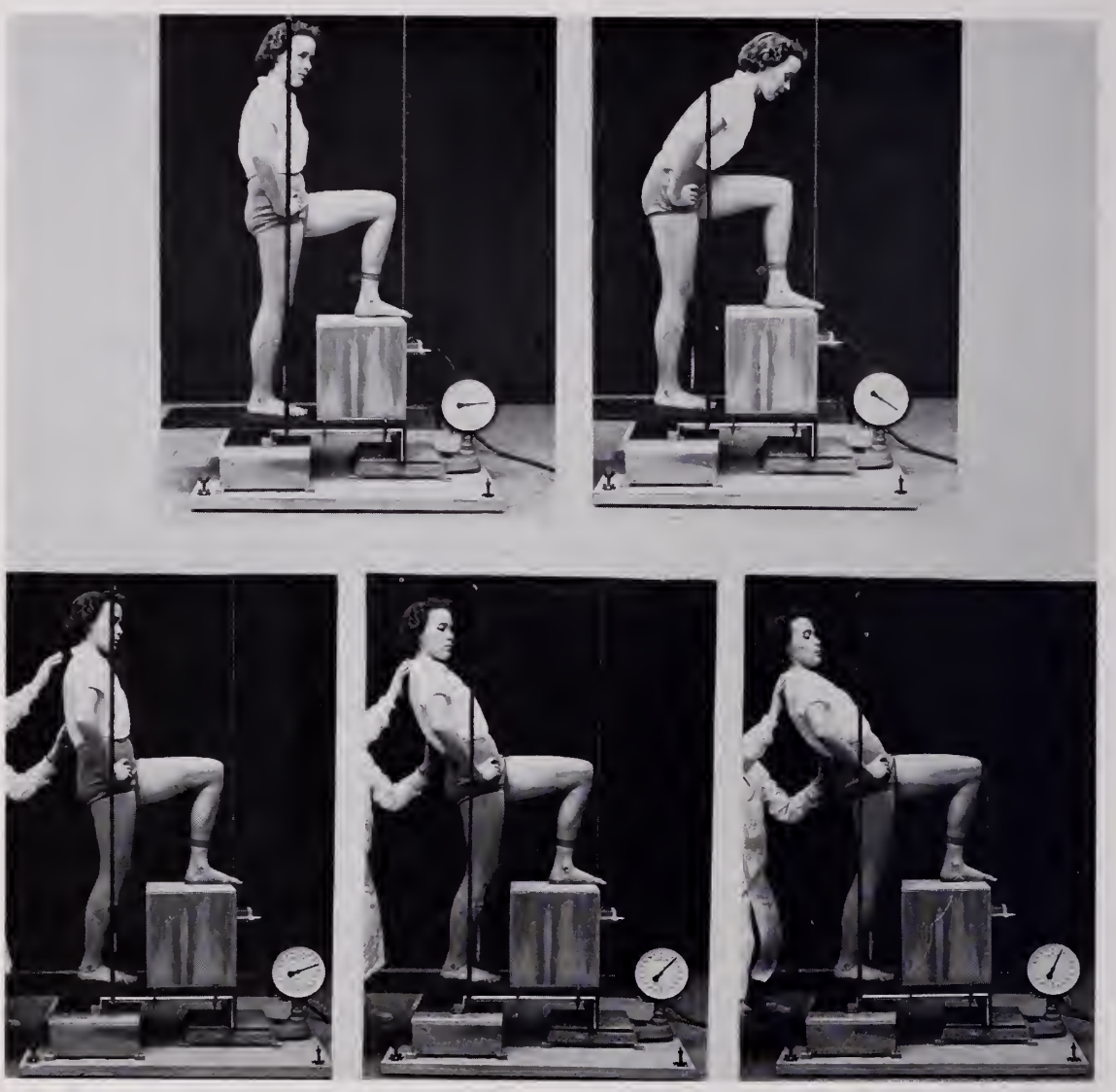


Fig. 7—Serial photographs illustrating the carrect performance of the Beevor Experiment. The key cue is voluntary fixation of the weight bearing limb.

or's interest a half century ago was the input from a special sense organ whose receptor is the retina. Suddenly, the subject perceived, as a visual image, an automatic response which she had been unable to introspect. Instantaneously this changed the mental design of the motor act to be executed. It led unerringly, without further ado or trial and error, to that fixation of the weight bearing limbs which was the *key cue* to the correct performance of Beevor's experiment. Sherrington had observed that "the mirror can tell us often more than can the most painstaking attempt to 'introspect'" (24:89). And it was Bartlett who said it is more important to know *WHAT* to do than *HOW* to do it. The *how* will take care of itself. It is not practice which makes perfect but practice *the results of which are known* which make perfect (3).

4. What was missing in our too cooperative subject, caught in some primordial miasma, was mentation. The neocortex had to be aroused in order to break up, by power of the will, a series of primitive protective reactions evoked for no purpose other than preservation of the constancy of the center of gravity of the body as a whole. This is an

example of physiological homeostasis. Once the intellective antecedent of movement was allowed to function, a specific stimulus responsible for a specific result made itself felt. It was an act of inhibition, i.e., cortical suppression of a spontaneous postural adjustment, that placed at the disposal of the subject a delicate means of grading gravitational stresses affecting the hip joint flexors. When the center of gravity was allowed to shift posteriorly, a critical point was reached at which equilibration was obligatory but satisfied by contraction of the sartorius alone. Augmenting the stress mobilized the equilibrating power of a second flexor, the rectus femoris. The subject could grade the stress which fired the effectors, but no power of the will could arouse their sequential contraction per se, or reverse the order in which they responded.

5. Serial photographs taken during a successful experiment demonstrate how imperfect localization of movement really is. To put this in another way, they demonstrate how tenaciously primitive responses resist cortical disruption in the interests of some unnatural or learnt movement.

The first view in Figure 7 is the starting position. In the second the trunk has reached its maximum forward position. The tendency of the buttocks and kneecap to move backward is obvious. The involuntary compensatory movement is reversed in the last view, where the trunk has reached its maximum position backward.

The postural alignment at which the sartorius was excited is that illustrated in the third view; in the fourth the rectus femoris came into action; in the fifth, there was augmented activity of the tibialis anticus in association with reciprocal inhibition of the soleus. The weight line now falls close to the geometric center of the supporting base. Many years ago I had said, in a long series of posture papers, that few physiological constants are guarded more jealously than the positioning of the center of gravity in relation to the diameters of static security (15, 16, 17, 18, 19, 20).

Everything we know about the mechanisms of voluntary movement suggests that all normal men will respond to Beevor's experiment in exactly the same way if the key cue is used with conscious effort. This unlocks a limb synergy operated by preformed, built-in synaptic arrangements. The magnitude of the stress necessary to generate a feedback capable of altering the configurational stimulus sufficiently to evoke mobilization of the hip flexors may vary from individual to individual, as well as other parameters of the response. Assessment of variables of this kind must also be made the subject of investigation, but this is a different kind of research, a second step as it were, designed to prove or disprove hypotheses arising out of attempts to explain phenomena observed.

It was inevitable that the availability of electromyography would re-focus attention on the muscles engaged in the production of movement. This experience has not been unique to us. As recently as 1954 LeGros Clark remarked that electromyography is teaching the anatomist how much he still has to learn about the anatomy of muscles. ". . . we have learnt, unexpectedly," he said, "that certain muscles may be quite inactive in movements or postures in which they have always been supposed to play rather an important part" (9:11). He then suggests that the anatomist get down as quickly as possible to the systematic study of patterns of muscular activity; the kinesiologist also needs to do this.

Physical educators have all but forgotten the anatomical basis of the activities comprising their programs. For decades biomechanics has usurped the stage. The end-results of the motor acts willed have been translated into mechanical units and then tested and measured by application of increasingly sophisticated methods. Preoccupied with the intricacies of these elaborate procedures, the biomechanical kinesiologist has become a superb archivist of valid and reliable facts. But he has forgotten to ask *why* the behaviors occur, and *how* they are implemented. He has lost interest in the machinery responsible for that beautifully integrated sequencing of the responses of privileged combinations of muscles which characterize precisely executed motor skills (23). It is the neurophysiologic approach to kinesiology which has been more or less bypassed at a time when what we know about the functioning of the nervous system has been leaping forward with one brilliant stride after another (1, 2, 5, 8, 12, 13, 14, 27).

Recent contributions to the anatomical literature like those of Smith suggest that

the electromyographic study of muscle function is much enhanced when combined with biomechanics (25, 26). Since the biomechanics of movement is a subject in which the physical educator is often more experienced than the biological scientist, a conjoint attack might be more productive than the efforts of either alone. The whole literature in this field is disappointing often because of failure to use the interdisciplinary approach.

I have thought often of that Sunday in December when the minds of five individuals focused on the preliminary task of confirming generalizations made by a predecessor whose observations had excited our interest and imagination. It was a Sunday because electrical interference from the neighboring hospital is less critical on that day. We work in an open laboratory and not in a shielded room. It requires several hours to get ready for an experiment of the type described, that is, to locate motor points by electrical stimulation, prepare and apply electrodes, test the accuracy of their placement, calibrate the recording equipment, load and test the cameras. The experiments themselves cannot be hurried. They may require five or six hours of uninterrupted observation, a time span difficult to arrange in the midst of the exigencies of everyday responsibilities. The atmosphere of the laboratory must be relaxed. Our team was composed of one subject and four observers, each trained for a particular operation. These are the limitations of electromyographic kinesiology. But they are no more stringent than those imposed upon the experimental scientists occupying countless laboratories in the Medical Center. Sometimes the lights burn throughout the night. There is no short cut to real knowledge. Students know this and respond to it instinctively. We never want for subjects, no matter how rigorous or time consuming our experimental procedures are. To stand shoulder to shoulder with the experimental scientist on the frontiers of human knowledge is an invaluable educational experience, and one many students are eager to share.

Is electromyographic kinesiology a practical tool for the physical educator? Yes, we think so. Dr. Waterland is testing its feasibility on the undergraduate level, working, however, through a cross-departmental laboratory whose base of operation for this aspect of our program is the Department of Anatomy of the Medical School. I would like to say in closing that the physical educator has a contribution to make in the unfolding of the story inherent in living anatomy. I believe it is a contribution of inestimable value. No one else is trained to make it. But the physical educator must qualify himself first, in the old fashioned "solid subjects," i.e., the basic sciences. Only this will give him entry to laboratories equipped to do modern biological research. And if he passes through the door thus opened, he not only serves his own profession, but may experience also the deep satisfactions which come from an opportunity to add to human knowledge.

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IN 1960 DOCTOR MIDDLETON opened a short-wave radio amateur network linking 30 VA hospitals. He broadcast the first message from the Brooklyn, New York, VA hospital station to the manager of the Roanoke, Va., VA hospital. Later, other VA hospitals joined the network.

AT THE TIME HE BECAME a member of the State Medical Society's "Fifty Year Club" in 1961, Doctor Middleton wrote the Society to express his gratitude for his certificate and pin. In that letter he called attention to "the importance of a careful assessment of the position of medicine in society, with a thought of readjusting our sights for the future," and he also repeated a sentiment voiced by Dr. Henry Favill in an address in 1909 before the Alumni of Rush Medical College: "The pathology of society is as much the function of the medical man as the pathology of human disease."

AT A MEETING OF THE Wisconsin Chapter of the American Academy of General Practice in 1949, Doctor Middleton urged the general practitioners to group themselves to give good medical care to every part of the state. He warned that "if we don't do it ourselves, the U. S. Public Health Service will do it for us—will tell us where to practice."

AT THE DEDICATION OF THE new State Laboratory of Hygiene building in 1953, Dean Middleton warned that concerted attacks must be directed against the diseases that have taken the place of conquered killers, which, he reminded, are still in the background waiting to strike again if the public relaxes its vigilance.

THE WISCONSIN GENERAL HOSPITAL UNIT was formally approved by the Surgeon General in November 1940 following his invitation to the University of Wisconsin Medical School to form an "affiliated unit." It was under Doctor Middleton's direction that this unit was assembled. It was stationed in Oklahoma.

A FLUENT SPEAKER Doctor Middleton (center) has always been an avid supporter of postgraduate teaching programs.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

The Tranquilizers

A Brief Review

By MICHAEL J. HOSKO, Ph.D., Milwaukee, Wisconsin

■ THE TERM TRANQUILIZER entered the medical literature relatively recently, and is used to designate a group of pharmacologic agents of diverse chemical structure, which have in common the ability to depress or suppress the central nervous system. Central nervous system depressants have been used from antiquity for the control and treatment of neurotic and psychotic states. However, the success of the tranquilizers as therapeutic agents in the treatment of the mentally ill appears to lie in the high specificity of the central actions of these drugs. Unlike the older sedative and hypnotic agents, which at therapeutic dose levels act primarily at the cortical level, the tranquilizers have been shown to act at various subcortical structures. These sites of action include the reticular formation which contributes to the control of the level of consciousness, the limbic system which modulates much of what is behaviorally evidenced as "emotional behavior," and the hypothalamus which acts as a trigger area and "final common pathway" for the primitive "fright, flight, or fight" responses.

The net effect of these specific central actions of the tranquilizing agents is to produce a state of behavioral calm without deep sedation. The patient remains in contact with his environment, is usually able to care for many of his own basic needs, and is accessible to psychotherapy. Although the tranquilizers are not cure-alls, and although they are not universally effective, they do provide, in selected cases, an attractive therapeutic alternative to psychosurgery, particularly frontal lobotomy or leukotomy; insulin, pentylenetetrazol (Metrazol), or electroconvulsive therapy; or the prospect of long-term close confinement.

On the basis of therapeutic effectiveness, these agents fall into one of two categories, the major and the minor tranquilizers. Table 1 provides a brief outline of these categories and lists a few examples of the member agents in each division.

TABLE 1—*An outline of tranquilizer classification*

I. MAJOR TRANQUILIZERS
- A. *Phenothiazine Derivatives.*
  - 1. Propyl dimethylamine substitution.
    - Chlorpromazine (Thorazine)
    - Promazine (Sparine)
    - Trifluopromazine (Vesprin)
  - 2. Alkyl piperidyl substitution.
    - Mepazine (Pacatal)
    - Thioridazine (Mellaril)
  - 3. Propylpiperazine substitution.
    - Fluphenazine (Permitil, Prolixin)
    - Prochlorperazine (Compazine)
- B. *Rauwolfia serpentina derivatives.*
  - 1. Whole root.
    - Rauwolfia serpentina (Raudixin, Rauserpa, etc.)
  - 2. Various fractions of Rauwolfia.
    - Deserpidine (Harmonyl)
    - Syrosingopine (Singoserp)

II. MINOR TRANQUILIZERS
- A. *Benzodiazepine derivatives.*
  - Chlordiazepoxide (Librium)
  - Diazepam (Valium)
- B. *Propanediol derivatives.*
  - Meprobamate (Miltown, Equanil)
  - Phenaglycodol (Ultran)
- C. *Diphenylmethane derivatives.*
  - Hydroxyzine (Atarax, Vistaril)
  - Benactyzine (Sauvitil)
  - Azacyclonol (Frenquel)

The major tranquilizers are characterized by their ability to relieve or to control frank psychotic manifestations, or states of extreme agitation. The phenothiazine derivatives appear to be particularly useful in the control of psychomotor activity, aggressive behavior, and hallucinations or delusions. Reserpine in its various forms has found its most extensive usage in the treatment of

mild, labile hypertension associated with some form of anxiety or tension. While reserpine is not widely used at present as a tranquilizing agent, early experience established its ability to control various psychotic symptoms.

The major tranquilizers, in common with most other potent therapeutic agents, exhibit a number of side effects. Some of these actions are really extensions of the therapeutic actions, some are secondary central nervous system or autonomic nervous system effects, and some are the result of idiosyncratic or allergic responses of individual patients. Side effects of the phenothiazine derivatives include: (a) extrapyramidal symptoms ranging from Parkinsonian tremors, rigidity and akinesia, to dyskinetic reactions with tonic-clonic contractions of various muscle groups, progressing in some cases to frank generalized seizures; (b) blood dyscrasias, in some cases irreversible; (c) jaundice, usually of the obstructive type, and usually reversible; (d) skin reactions; (e) orthostatic hypotension; and (f) sedation. In most instances simple discontinuation of the particular agent will effectively control the side effects. In many cases later resumption of treatment with another agent, or even the same agent at lower dose levels will provide effective control of the original symptoms. The major side effect of the reserpine series when utilized as tranquilizers is postural hypotension. The most serious side effect following high dosage is the occasional development of a paradoxical suicidal depression.

The minor tranquilizers are utilized for their ability to provide symptomatic relief in neurotic syndromes, in simple anxiety states, and as an adjunct in the treatment of apprehension and anxiety associated with somatic disease states. For the most part these agents have little or no therapeutic value in the treatment of frankly psychotic individuals, or in the control of severe agitation states. A number of investigators have suggested that the effects produced by the minor tranquilizers are essentially the same as those produced by the older CNS depressants, particularly the barbiturates; however, the relatively lower levels of sedation produced by the minor tranquilizers, coupled with their much lower toxicity give these agents a distinct therapeutic advantage over the older drugs.

A characteristic of all members of this group is the production of mild sedation. In addition to the sedative properties, the benzodiazepine derivatives and the propanediol derivatives produce at least a partial blockade of interneuronal neurons, particularly at the spinal level. This action may account in part for the muscle relaxant properties of these two classes of agents. Both the benzodiazepine and the propanediol derivatives exhibit substantial anticonvulsant properties in experimental animals, and these agents, or future congeners of these agents may find clinical usefulness in the treatment of some convulsive disorders. The members of the diphenylmethane series of compounds exhibit somewhat diverse properties including antihistaminic and anticholinergic actions in addition to their basic calming effect.

As a group, the minor tranquilizers have few serious side effects. Excessive sedation occurs in some individuals and massive overdosage may result in coma with possible cardiovascular collapse or respiratory failure. Minor side effects include dizziness, mild ataxia, and headache.

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* * *

"A GRANTING AGENCY IN CLINICAL PHARMACOLOGY?". It is well known that members of the pharmaceutical industry have generously supported a great deal of basic research. That it has paid off, and paid off well in some cases, is the strange and wonderful fact of life that is the text of this talk. I think that industry as a whole must continue to support basic research, if only for the defense of the drugs it markets. . . Maybe industry as a body could be persuaded to establish a granting agency in clinical pharmacology. It would consistently maintain the highest standards for grants by industry. Industry has the scientific stature. I suspect it can get the funds. It certainly has the know-how to be both efficient and effective.—WALTER MODELL, M.D., in *Clinical Pharmacology & Therapeutics*, 5: 2 (March-April) 1964.

Tribute to Doctor Middleton

THE WHITE HOUSE

WASHINGTON

February 25, 1963

Dear Dr. Middleton:

From the outset of this administration, I have emphasized the great need for Americans who will dedicate their efforts to the public interest. To all the citizens of the country, I said: "Ask not what your country can do for you; ask what you can do for your country".

On your retirement from the federal service, I am impressed by the example your life provides of the completely selfless dedication of an individual to the needs of mankind.

Your choice in your early years of vocation as a doctor bespeaks your interest in your fellow man. The flowering of your ability as Dean of the School of Medicine of a great university redoubled your contribution as you taught the oncoming generations how to care for human ills.

In two wars, you answered the call of your country's need and bound up the wounds of her sons who served. This much alone represents more than most men have to look back upon. And yet, in your years of golden wisdom and maturity, you entered directly in the government's service to the veteran.

In the past eight years as Chief Medical Director, Veterans Administration, you provided vision, imagination, and leadership that molded and energized the medical program of the Veterans Administration. Your pioneering ideas and tireless efforts to improve patient care, medical education for the staff, and advanced research have carried these programs to a pinnacle of effectiveness.

We salute you for a lifetime of achievement in which you are second to none among those who have served the medical needs of the veteran.

Sincerely,

Dr. William S. Middleton
Chief Medical Director
Veterans Administration
Washington 25, D. C.

WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

THE MAGNITUDE OF DOCTOR MIDDLETON'S CONTRIBUTIONS to the welfare of the people of his Country is clearly recognized in a letter from President John F. Kennedy upon Doctor Middleton's retirement as chief medical director of the Veterans Administration and from the personal thanks in a meeting at the White House.

■ IT IS FITTING at this time to recognize a distinguished colleague who has gained an international reputation as an outstanding clinician, an able administrator, an exceptional medical historian, and a great humanitarian. He is William Shainline Middleton, M.D., emeritus dean of the University of Wisconsin Medical School and recently retired chief medical director of the Veterans Administration.

For more than 50 years Doctor Middleton has served the medical profession and the people of Wisconsin, the Nation, and the World.

This special issue, which contains a number of scientific articles written by a few of his students and colleagues at the request of the editors, and a resumé of his full and rewarding life, records the appreciation and warm regard so deserving to Doctor Middleton.

The Editors and Editorial Board wish to thank all those who assisted in the preparation of this issue, and express sincere best wishes to Doctor Middleton.

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A MEMORABLE HANDSHAKE—Dr. William S. Middleton, President John F. Kennedy, and John S. Gleason, Jr.

Special Editorial: William Shainline Middleton, M.D., reprinted from the *Wisconsin Medical Journal*, July 1935.

A NATIVE OF Pennsylvania, born at Norristown, Montgomery County, Pennsylvania, 1890, he received his degree of doctor of medicine from the Medical School of the University of Pennsylvania in 1911. After serving residencies in the Philadelphia General Hospital and Babies Hospital in Philadelphia, he came to the University of Wisconsin as an instructor in clinical medicine in the fall of 1912. His development as a nationally-known teacher and clinician has occurred in the State of his adoption. His service to the University of Wisconsin has been continuous except for the period of two years spent overseas with the Medical Corps of the American Expeditionary Forces.

Dr. Middleton, therefore, was intimately associated with each stage of development of the clinical courses in the Medical School. The character of his work during those early years had a most important influence upon the formation of plans of organization and of clinical teaching. He was advanced to assistant professor in clinical medicine in 1915, and was placed in charge of the Student Infirmary upon his return from overseas service in 1919. From this time up to the opening of the clinical courses in 1925 he was laying the foundations for the methods of clinical teaching and ward organization later established, and at present more completely developed by his efforts in the Wisconsin General Hospital. In 1925 he was advanced to associate professor in medicine and in 1933 to professor in medicine. During his twenty-three years of service to the University he has been an indefatigable worker. He has been, in a large measure, responsible for the orderly coordination of the clinical teaching in its relations to the medical sciences. As a teacher, his accuracy has inspired the students to greater en-

deavor. He has insisted upon a logical and humane application of the medical sciences to human welfare. In his clinical research he has always shown critical judgment, which has given to his accurate observations helpful practical significance. His enthusiasm has not only stimulated his students, but his colleagues as well, to more careful clinical investigation. Because of his mental capacity, his physical energy, his ability to organize, his interest in the work of others, his proper sense of values, and his great human sympathy, his selection as Dean of the Medical School is most fortunate.

Tribune Personality Report: THE HIGHEST TITLE OF ALL, Dr. William S. Middleton, reprinted from the *Medical Tribune*, May 31, 1963.

WASHINGTON, D. C.—Dr. William S. Middleton, who recently retired after eight years as Chief Medical Director of the Veterans Administration, will be far from inactive in the future.

After a few months at his home in Madison, Wis., Dr. Middleton at 73 will take on a new career as visiting professor of medicine at the University of Oklahoma Medical Center.

Keeping Dr. Middleton on the job here three years after the retirement age of 70 took formal action by VA and the Civil Service Commission. Sumner Whittier, then VA Administrator, said he was needed to carry on the job of directing the largest hospital system in the world and running what amounts to one of the largest medical research operations in the world.

The VA department of medicine and surgery now covers 169 hospitals, 18 domiciliaries, and 93 outpatient clinics. About 75 medical schools now cooperate with VA in education training programs, with about 7,800 junior and senior medical students using VA hospitals for training.

Looking back on his eight years as Chief Medical Director, Dr. Middleton says that perhaps the greatest single contribution of the VA to medicine has been in its development of more effective therapies

THE SAME STETHOSCOPE for over half a century.

DECORATED WITH HIGHEST HONORS—Doctor Middleton and General Omar Bradley.

for tuberculosis through its collaborative research projects.

Thus, he is proudest of the fact that VA has reduced its tuberculosis hospitals from 21 to five since 1954. There are 6,150 tuberculosis patients, as against 15,960 in 1954.

Another important contribution, he told MEDICAL TRIBUNE, has been its help in recognizing psychosis as a true disease. VA research programs illustrating the causes and therapy of psychoses have been instrumental in this regard, he said. Pioneering efforts by VA in use of tranquilizers have paid off handsomely, he adds.

. . . he points out that 37,000 physicians are participating in the VA hometown care program of patients on a Government-financed fee-for-service basis . . . Dr. Middleton firmly believes, as he leaves office, that the quality of patient care and medical research and the maintenance of high standards of staffing must remain the permanent objectives of the VA system.

Looked Forward to Quiet

Dr. Middleton had not planned to come to Washington in 1955 after 43 years of service at the University of Wisconsin Medical School, including 20 as dean. He was looking forward to five years of quiet clinical instruction and research, free of administrative headaches.

But Harvey Higley, then VA administrator, talked his old friend, Dr. Middleton, whom he knew from his Wisconsin days, into taking the top medical post. And Dr. Middleton hadn't been able to leave the position until his recent retirement, despite efforts to do so.

Dr. Middleton still considers himself a clinical internist and a teacher, and promises that he will combine both in his University of Oklahoma position.

"I'll be back at the patient's bedside, you can bet on that," he says.

Dr. Middleton has been associated with the veterans' medical program in a variety of part-time

consultative capacities dating back to 1922, when he served the former United States Veterans Bureau as an attending specialist in tuberculosis.

He was one of the original members of the VA Special Medical Advisory Group established by law soon after World War II (1946) to advise the VA Administrator and Chief Medical Director concerning the care and treatment of disabled veterans. It was this group that was instrumental in establishing the close association between VA and leading medical schools.

During Dr. Middleton's service, the VA program has been marked by expansion of hospital facilities for long-term care of aging veteran patients, and by enlargement of medical research to include nearly 6,000 projects covering virtually every condition known to increase in frequency with age.

He received his M.D. from the University of Pennsylvania in 1911 and joined the faculty of the University of Wisconsin Medical School the following year. He became dean in 1935. He served with the British Expeditionary Forces and American Expeditionary Forces in France in World War I, and also took time out in World War II to get into uniform, serving as chief consultant in medicine for the European Theater of Operations.

He received the Distinguished Service Medal and the Legion of Merit with Oak Leaf Cluster of the United States Army, and has been decorated with the Croix de Guerre with Palm by France. Great Britain has conferred on him the Order of the British Empire.

One of the Toughest

Dr. Middleton has long been known as one of the toughest officials in Washington to interview. Modesty overtakes him early in the interview, and little of a "personal" nature comes out. But VA Administrator John S. Gleason, Jr., put it this way:

"As a practicing physician, as a historian of medicine, as a dean of a famous medical school, he carried a rich cargo of knowledge and skills to his job as leader of the largest single hospital system in the world.

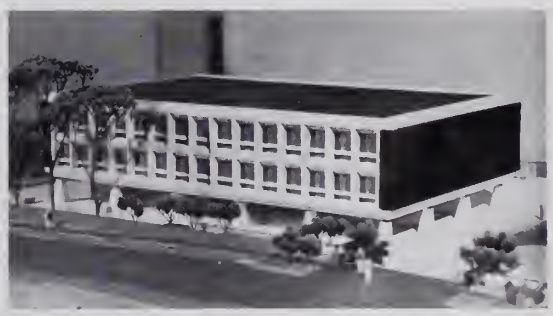
"If this were all, it would have been more than sufficient. But Bill did more. He brought his own deep feeling for human beings. He brought his own humane vision of the nature of the department of medicine and surgery and has been an inspiration as well as leader, guide as well as administrator, dear friend as well as counselor."

President Kennedy also took the unusual action of summoning him to the White House for a personal expression of thanks and good luck for the future.

As to the future, Dr. Middleton is anxious to return to clinical medicine and teaching. Above all, he wants to retain his identity as a practicing physician, which he regards as the highest title of all.

Hippocrates Type Tree Planted

IN A LITTLE CEREMONY in June 1963, a Greek plane tree of the type Hippocrates taught under was planted in front of the University Hospitals and the Medical School by Doctor Middleton and a few representatives of the University of Wisconsin Medical Center. The tree is one of the three "Mediterranean Sycamores" brought by the Greek ambassador to the United States for a ceremonious planting at the National Library of Medicine in Bethesda, Md. Doctor Middleton obtained it for the Medical Center.



Medical Library Approved

THE UNIVERSITY OF WISCONSIN Board of Regents October 16 approved preliminary plans and specifications for Phase I of the Medical School Library, to be located on Linden Drive in Madison. It will eventually be named in honor of *Dr. William S. Middleton*, former dean and now emeritus professor of medicine. About $800,000 of the $1,100,000 needed for Phase I was secured by the Wisconsin Medical Alumni Association via private and industrial contributions, the remainder coming from a state appropriation. Total cost of the project expected to be completed before 1972, was set at $1,750,000. It is to be erected between Children's and Bradley Memorial hospitals, and be 135 feet wide and 81 feet deep. The north side of the structure (front view above) will hold stacks and space for readers, while the south area will be used for work space and offices. Helen Crawford, Medical School librarian, said the library now consists of 90,000 volumes and more than 1,000 periodicals.

HOSPITAL SERVICE

EDITOR'S NOTE: "Hospital Service" was written by Doctor Middleton in 1922. It is from the files of the late Doctor Harold M. Coon, formerly Superintendent of Wisconsin General Hospital. Doctor Coon had saved the paper from his intern days at Bradley Memorial Hospital and the Student Infirmary. The thoughts and truths expressed in this early paper are still cogent.

Forty years later Doctor Middleton wrote an editorial, "Let's Give the Hospital Back to the Patients," for the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA. *This essay updates and expands the earlier remarks making it appropriate for modern hospitals.*

UNIVERSITY HOSPITALS

UNIVERSITY OF WISCONSIN MEDICAL CENTER
MADISON, WISCONSIN

Dear Bill:

It is good that you are to be honored by this appropriately conceived *Festschrift*, and I am glad to have the opportunity to be a participant.

You and I first met in 1919, when you had just returned as a Captain from World War I and one evening talked to a group of pre-medical students in a Science Hall laboratory. Afterwards we walked together as far as the old red Clinic Building on Langdon, where the Memorial Union now stands. Our next meeting was in the spring of 1923, when you were in charge of the Student Infirmary and I was a patient for eight weeks. Then we really became acquainted, and our friendship dates from that time. I readily remember being in Madison in the summer of 1925, after my junior year in medical school, when you showed me through the Wisconsin General Hospital then under construction. Happy memories! And I recall with pleasure our many encounters and visits, and the correspondence spanning 40 years—from the time of your assistant professorship, through your deanship, and to the present time. It has been my privilege through all these days to be your pupil and colleague.

For more than 50 years you have been a dedicated citizen of Wisconsin, with a sustained interest in our wonderful state, our University, and the Medical School. At all times you have been a true friend of the interns and residents and an inspiration to generations of medical students. I could enumerate most of your honors of distinction from our University, the state, the nation, and the world; and there are many other significant, yet unpublicized, tributes of which you yourself are probably not cognizant. I cite one—Sir Lionel Whitby, whom you admired and respected, said to me when visiting Madison shortly after World War II, as we were walking along the corridor in the Medical School and referring to your efforts in the war as chief consultant: "Old Bill did more to cement good relations between the American and British medical people than anyone over in Europe!" I recognize very well some of the implications of this remark, since they are deeply meaningful. The patients—the service men of the war, in

continued on page 543

■ AT THE OUTSET let it be understood that the following suggestions are not made in a spirit of criticism nor with a thought of reconstructing human nature over night. It is, however, hoped that they will be received in the same spirit of cooperation with which they are submitted.

Fundamentally our function in relation to this hospital is one of service. Regardless of your particular duties the ultimate thought in your conscientious performance of them should be the welfare of the patient. Therefore your attitude toward superior and subordinate in this organization must consider only the good of the patient. Selfish interest and personal comfort should be sacrificed on every hand to the best interests of the patient.

To this end our organization has been arranged to divide responsibilities and to delegate certain definite duties to each individual—responsible in turn to a given coordinating head. Realizing your individual responsibilities, discuss your problems with your direct superior. "Shortcuts" and conscious evasions of authority are certain paths to discord. Were discord individualistic, it might be tolerated or overlooked; but harmony is the keystone of hospital organization and any disturbing element must be eliminated for the ultimate protection of the patient.

With a clear idea of your responsibility to self, patient and organization, certain special phases of the less obvious functions of hospital employees may be considered. Courtesy toward associates, patients, visitors and tradespeople entering our group indirectly should be a ruling motive. Universal courtesy in our contact leaves a particularly pleasant remembrance of such associations in the minds of patients and visitors. This courtesy should be particularly stressed in telephonic conversations and in cases where the message conveyed is distasteful to either party. Curt replies to proper inquiries avail nothing. It is furthermore desired that non-committal answers be avoided in so far as is possible. Particularly in regard to the admission of patients should the nurses either personally or through the resident staff give proper instructions as to the method of obtaining medical attention or transportation to the hospital. It is by the unusual ex-

igency that we are judged; our conscientious performance of routine duties is overlooked, if we fall down in emergencies.

A certain decorum and quiet dignity in contact with our coworkers and patients brings confidence and cooperation which need scarcely be reiterated. Furthermore the well-being of our patients demands every protection of his disordered mind or body from the needless shock of unnecessary noise or confusion. To the very sick, the convalescent and the nervous patient it is the small attention that counts, a kind word, a tasty tray, a sympathetic understanding. Do not (even mentally) discriminate between the physically and the nervously sick—unless it be to the advantage of the latter. In this respect it might well be emphasized that treatment by suggestion or other psychic methods in such cases should remain entirely a function of the medical staff.

A cheerful manner is essential to the proper care of the sick. Avoid affectation; but if your presence does not "buck up" the patient, your contact is harmful. Never permit by word of mouth or manner the suggestion of a change for the worse to be charged at your door. Cultivate a poker face. Many efficient and intelligent hospital attachés fall short of true success through lack of personal cheer. The patient uses you as a mental and moral prop. Do not fail him.

Be on your toes. Alertness may save a life. Nor is this responsibility medical and nursing alone. The occasion may arise when the life or health of an individual will be dependent on your prompt performance of your duties or recognition of an emergency whose proper handling will be the deciding factor in life or death.

Your cooperation in the prompt reporting of illness is earnestly sought. If for no other reason, the protection of the patient should be a paramount thought in this matter.

In conclusion remember that yours is a life of service not to self or small motives, but to organization and human life.

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this instance—received the greatest gain from this good relationship, and, if there had been poor relations, the patients would have been the chief losers.

President Kennedy, in his letter of tribute upon conclusion of your term of duty as Chief Medical Director of the Veterans Administration, expressed emphatically your great service to this country and to your colleagues during all these years until the present time.

Your many skills and rare qualities as a physician, teacher, scholar, counselor, and warm friend, I shall always cherish. Your uncompromising integrity, kindness, and unfailing concern for others rather than yourself, we have all appreciated and shall forever admire. When President John F. Kennedy, in his inaugural address, made his most frequently quoted and probably eternal statement, "Ask not what your country can do for you—ask what you can do for your country," I thought that, among those I knew, no one has throughout his lifetime more clearly fulfilled the admonitions of this statement than have you. I have always been impressed by your truly sincere, self-effacing patriotism—one of the finest of your many virtues. One of my greatest fortunes has been to have you as a close friend for all these years, a relationship which I trust will extend far into the future. And I anticipate that you will continue with your usual avidity and tremendous enthusiasm, your search for answers to the enigmas of medicine, solutions to the problems of medical education, and facts in the recording of medical history.

My sincere best wishes for your happiness and good health upon this occasion and for the years to come.

Sincerely,

Ovid O. Meyer

OVID O. MEYER, M. D.
Professor of Medicine

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE
MILWAUKEE, WISCONSIN

Dear Doctor Middleton:

It is a pleasure for me and the faculty and students of Marquette University School of Medicine to join in celebrating the recognition of your countless accomplishments. Your rewards in friendship and esteem have been flowing your way for many years, and now that your cup is full we hope you will have many years to enjoy the rich vintage of a most productive life.

John S. Hirschboeck

JOHN S. HIRSCHBOECK, M.D.
Vice President and Dean

"LET'S GIVE THE HOSPITAL BACK TO THE PATIENTS!"

VETERANS ADMINISTRATION

OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C.

Dear Doctor Middleton:

It is indeed a pleasure to join with so many others who are using the opportunity presented by this *Festschrift* to express their admiration for you and for your accomplishments.

As Chief Medical Director of the Veterans Administration, you were responsible for all operations of a medical program which is not only the largest under a single administration in the world, but also one which has a mandate from Congress to provide medical care second to none.

To direct this enormous program, which includes medical care, research, and training of half the nation's physicians, the nation needs the very best talent that American medicine can supply. To operate the superlative instrument of medicine that is the Veterans Administration medical program we sought nothing less than a superlative man, a man who combined unmatched understanding of medicine with a deep compassion for the suffering; a man who was statesman and scholar, administrator and advisor. I know that it is no secret to say that the nation found all these rare gifts in you—and more.

When you left the Veterans Administration, you left behind you a tradition enriched by your spirit; a structure strengthened by your abilities. As you recall, when President Kennedy, who was deeply aware of the significance of your service and the importance of your position, called you to the White House, he said, "I am impressed by the example your life provides for the completely selfless dedication of an individual to the needs of mankind."

To those words I can add no more, for no greater accolade can be given to any man.

Sincerely,

J. S. GLEASON, JR.
Administrator

■ HISTORICALLY derived, the hospital originally served as a refuge for weary and disabled travelers. Later, its functions in the care of the ill and handicapped received their greatest impetus in the Christian Era; but even the most visionary of earlier generations could not have pictured the hospital of the Twentieth century, as we know it. Almost inevitably, in the mechanization and sophistication of this complex organization that we term the modern hospital, there has arisen a certain impersonality that threatens its greatest service to humanity. Hence, when one of my associates, Doctor J. Herbert Smith, recently gave vent to his feelings with the expression, "Let's give the hospital back to the patients!", I realized that he spoke from the heart. Upon reflection, many circumstances serve to reemphasize the growing concern of many friends of medicine in this significant matter.

With illness, not infrequently one encounters a new or a renewed sense of dependence upon the part of the patient. Pain is a great leveler. Varying degrees of stoicism may modify the given individual's reaction to this most common complaint. The appearance of symptoms foreign to the common experience creates a sense of doubt and insecurity in the minds of the patient, which finds augmentation when the patient is left to his own devices to resolve the intangible manifestations of disease. At night, the shadows magnify the psychologic hurdles and these questions are multiplied. Singularly, illness enhances both the strengths and weaknesses of a given patient. In general, however, dependence upon the physician or the medical attendant is accentuated; and, to this end the dislocation from normal daily activity and human interchange lends added weight.

Transported to the modern hospital for stay and care, the patient meets with the receptionist and

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Editorial, published in the February, 1962 Number of MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, Volume 31, Number 2.

members of the staff. Undoubtedly, the most important link in this transition is the first one who greets the patient upon entrance to the hospital. The reaction at this critical moment may determine a ready acceptance or a resistance amounting to actual hostility to his surroundings. Hence, it is extremely important that easy rapport be established at this point. The heart of the hospital will be adjudged both by the patient and the family from the human warmth of the admitting office and the sick room (or ward). No pains should be spared in the selection and indoctrination of staff members who will meet these simple but vital functions. In this strange atmosphere, the patient will be prepared for bed and all personal belongings will be checked for safekeeping. From the austerity of the common hospital room, some coldness has been removed by warmer, less conventional furniture and softer colored drapes and pastel tinted paints.

Regardless of these minor concessions in the interest of the patient's comfort, hospital routines have fallen into certain scheduled hours that are entirely foreign to the habits of the patient. For example, the waking at five to six o'clock in the morning for the routine taking of the temperature, pulse and respiration, washing of the hands and face, brushing of the teeth and combing of the hair, presumably sets the schedule for the seven o'clock breakfast. Thereupon, after appropriate baths and bed-making, the floor is in order for the visits of the attending physicians. The luncheon and dinner hours are again set according to a formula that does not consider the patient's accustomed manner of life. In general, the nutriments and drinks that are served with and between meals are designed to meet the dietetic requirements of the given patient; but little advance has been made in affording attractive meals and appropriate portions to the taste of the individual. From personal observation over many years, the acceptance of hospital diets is largely overlooked, if one may judge from the rejections. This circumstance should be a responsibility not only of the dietitian but of the physician and nursing attendants.

To add to the indignities of the patient, the use of the unnatural bedpan and urinal is imposed. The latter may prove a convenience; but little advantage has ever been ascribed to the teetering bedpan, the control of which presupposes certain acrobatic abilities in the user. Indeed, recent studies have established the greatly increased physical effort that is employed in its use as compared with the bedside commode. Notoriously, physicians have paid scant heed to the wastage of time and patience in the waiting rooms of their offices; but it is almost inconceivable that such inefficiency should be tolerated in the x-ray and other special laboratories of a modern hospital. To compound this patent fault, the entire institution and its maximal operation is geared to the

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

CHICAGO, ILLINOIS

Dear Bill:

True greatness is rare among men, and yet it is apparent.

It was my privilege to have known you when you headed the largest medical and hospital program in this nation, a program supporting 145,000 veterans. The contributions you made to literally thousands upon thousands of veterans and their families by improvement in the quality of medicine are beyond measure.

But the genius that makes up this greatness is not alone your tremendous knowledge, nor is it your understanding of medicine and of administrative concepts. It is something more. It is your ability to like, and be liked by, people—to get them to work together. It is the towering respect with which you are held by professionals and laymen alike at all levels.

The truest measure of greatness is not only the regard of those who are colleagues, but those who are subordinates. Bill, you are loved by all who worked for you, and the long steps VA was able to take forward under your leadership were due to the willingness of so many people to work in harness and follow where you pointed.

Rather than attempt a roster of specific accomplishments, I should like to recount one facet of your service in VA which I shall cherish for a long, long time. This is your personal concern for individuals and your deep dedication to medicine. It was evidenced each Thursday afternoon when, medical bag in hand, you started off for Mt. Alto Hospital and personally examined patients. Few executives in VA ever attempted visits to as many far-flung hospitals and clinics as did Bill Middleton. You were determined there would be a high quality of medical care every place within that great system, and equally determined you would know this was so because you had witnessed it yourself.

The nation, its veterans, the medical profession, administrators—all owe you a great debt. Every best wish from one of that large group.

Warmly,

Sumner G. Whittier

SUMNER G. WHITTIER
Executive Director

40-hour week with the occasional concession of an added half-day on Saturday. Illness and disability know no moratorium in time. Patients are ill 24 hours a day, 7 days a week, 365 days a year. Of course, emergencies over the weekend are regularly met by cadres of key personnel in all well run hospitals; but the curves of occupancy, admissions and discharges in the vast majority of the hospitals tell an eloquent tale of ineffectiveness and wastage that is receiving renewed attention in certain quarters.

In a hypercritical vein, Robert Ruark wrote, "You will see signs all over the hospital which read, 'Quiet'. The patients are quiet. But the staff is about as quiet as New Orleans during Mardi Gras. The nurses are all rude, orderlies scream and yell, the swill is better than the food, and the service pure Mills Hotel". Granting the excesses of reportorial license, certain of these points are valid and by the same token ready of correction. The quiet and peace of the sick room should permeate the corridor, nurses stations and service areas. The several mobile carts and chairs require periodic greasing to minimize irritating squeaks. In many hospitals, plastic or rubber mountings have silenced the clatter of waste baskets and cans; but too frequently anxious patients await the din of garbage collection in hospital courtyards at the break of each day.

As these circumstances are reviewed and our reciprocal responsibilities are brought into focus, it becomes increasingly apparent that many of the details of the hospital care are determined in the primary interest of the staff without due consideration for the comfort and convenience of the parties of the first part, the patients. Obviously, each and every one of these details should be subjected to careful study and evaluation. Where the staff is primarily involved and the patient inconvenienced, they should be modified or corrected. Furthermore, such practices as would lead to added comfort of patients without serious dislocation of their own care and of the staff activities should be initiated in the interest of the former.

With few notable exceptions, hospitals of whatever order—sectarian, private or governmental—are constructed in the interest of the health of the community from private or tax funds. While members of the medical profession pay their share in these respective sources, there is no justification for the position that the ultimate buildings that constitute the hospital should be our vested interest. By reason of the technical order of our profession and its co-professional supporting staffs, physicians must play a major role in the operation of hospitals; but we should bear in mind that the health of the people and its projection is not an exclusive prerogative of medicine. In the interest of balance and sustaining support, far-sighted physicians have generally encouraged the active participation of public-minded citizens on hospital boards of directors. And this is the natural state of mutual respect that should exist in a democracy.

Resolved to least common denominators, "medicine exists for the benefit of the afflicted and not the afflicted for the benefit of medicine". With the astounding growth of the modern hospital, new problems and perplexities have arisen. Not the least among these has been an oversight of our primary responsibility to the patient. Quantitatively and qualitatively, this movement has been relative but appreciable. The time is ripe for a careful review of every procedure

THE UNIVERSITY OF WISCONSIN

DEPARTMENT OF MEDICAL MICROBIOLOGY
MEDICAL SCHOOL
MADISON, WISCONSIN

Dear Bill,

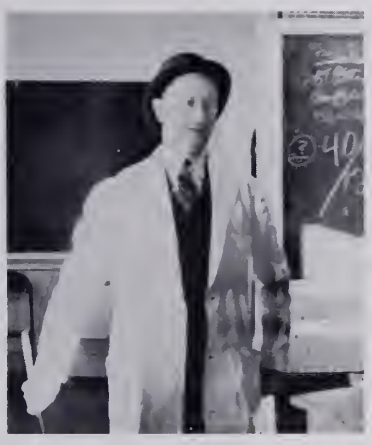
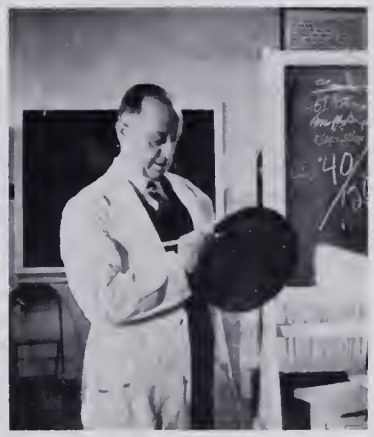
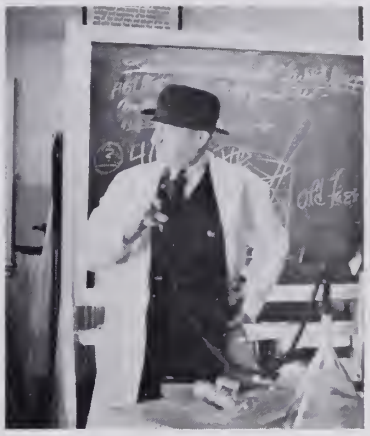
It is indeed a warm pleasure to think back over the many years of my association with you, as our physician, as colleague and as friend. As I wander back through the half century, I think first of the lively discussion group, the transplant from the old "Boston Bug Club" that did not survive the First World War. I have prized your understanding treatment of my mother, your acute reports in the clinical pathological conferences and the clinics, and your continuing productive interest in many phases of medicine and in medical history with special emphasis on the early physicians of your beloved Philadelphia. The memory of chance meetings in the hall or at lectures and the delightful social gatherings under family roofs recur again and again, adding much color and broad interest to the pictures. Your excellent leadership as Dean of our Medical School and your stimulating friendship have guided and helped us all.

We are delighted that you and Maude are returning to Madison. I hope affairs can be arranged so that you may again occasionally pass out the "brown derby" to sharpen the wits of our students. Current faculty members will, I feel sure, welcome a bit of your prodding when they falter. We all do need you and value deeply your wise counsel and helpful friendship.

Faithfully yours,

Paul F. Clark

PAUL F. CLARK
Emeritus Professor of
Medical Microbiology

Doctor Middleton and the "Brown Derby" method of teoching.

involving patient care by every member of the hospital staffs throughout the length and breadth of the land. The leading question should be, "How does this procedure or arrangement affect the patient?". Where his human dignity and his physical or psychologic comfort have been sacrificed in the interest of some inconsequential or unproved advantage to the staff, it should be amended without delay. Then and then only will the medical profession and its co-professional supporting cast take their proper positions as servants, not masters, of their patients.

"Let's give the hospital back to the patients!"

DOCTOR MIDDLETON HEADS NEW DRUG RESEARCH BOARD

It was announced in January 1964 that Dr. William S. Middleton would head the new Drug Research Board of the National Academy of Sciences—National Re earch Council, its function being to provide effective liaison among the scientific community, the medical profession, the drug industry and the federal government.

Dr. R. Keith Cannon, chairman of the NAS–NRC Division of Medical Sciences, said the new board does not expect to become involved in evaluating the safety and efficicacy of individual drugs unless those judgments affect the general conduct of therapeutic research. But its services will be available to the Food and Drug Administration and other public and private health agencies who seek advice on scientific questions of "broad significance" in the drug field.

VETERANS ADMINISTRATION

DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C.

Dear Doctor Middleton:

It is indeed both a pleasure and a privilege to be asked to contribute a few words to the William S. Middleton Festschrift. I first met you in England in the summer of 1942, and for three years was one of the many physicians who was subject to your influence as a physician of both high ideals and tremendous professional ability. From you we learned to better appreciate the value of human life, the meaning of devotion to duty, the value of unfailing optimism coupled with the willingness to work for long hours under rigorous conditions to provide the American soldier with the best medical care that American medicine could provide.

Now, after twenty years, it has been my unusual privilege to succeed you after eight years of your leadership of the Veterans Administration Medical Service. Everywhere in this organization I have found ample evidence of your superb leadership of the physicians, dentists, nurses, and other personnel who provide medical care to the veterans of the Nation.

Yours has been a remarkable and a full life. You have given much service to the Nation, both in and out of government service. Not only does that Nation owe you a debt of gratitude, but I personally owe you for much that I learned from you in World War II and the opportunity to observe your works of more recent years.

I am indeed proud to have the opportunity to express my admiration and gratitude.

Sincerely,

Joseph H. McNinch

JOSEPH H. McNINCH, M. D.
Chief Medical Director

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5. The Effect of Athletic Training on the Heart, American Physical Education Review, March, 1915, 1–15.
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7. The Influence of Athletic Training on Blood Pressure, Amer. J. Med. Sci., September 1915, No. 3, cl, 426.
8. Endamebic Pyorrhea and its Complications, J. Amer. Med. Assn., Jan. 30, 1915, LXIV, 422–5. (With Evans, J.S.)
9. Tonsillar Endamebiasis and Thyroid Disturbances, Amer. J. Med. Sci., Feb. 1916, cli, 210. (With Evans, J.S. and Smith, A.J.)
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19. Lower Lobe Pulmonary Tuberculosis, The American Review of Tuberculosis, July 1923, VII, No. 5, 307–13.
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21. The Present Status of the Management of Diabetes Mellitus, Wisconsin Med. J., October 1923, XXII, No. 5. (With Coon, H.M., Gilman, R. L., Overton, O.V. and Sevringhaus, E.L.)
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MAJOR GENERAL PAUL R. HAWLEY

U. S. A., RETIRED
SHADY SIDE, MARYLAND

Dear Bill:

I have been honored with an invitation to contribute a letter to your Festschrift and it is a very great pleasure for me to do so.

I have often said publicly that such success as I may have enjoyed has been due largely to the efforts of those with whom I have been associated, and among these you are in the front rank.

A list of your contributions to the medical service of the European Theater of Operations in World War II would fill a volume; but I was especially impressed with one characteristic of your performance of duty as Chief Consultant in Medicine: You never ceased being a teacher. Grand rounds with the local staff became an essential part of every visit to our hospitals. Even a great war, with hundreds of thousands of casualties, could not change the habit of a lifetime.

I watched with sympathetic approval your conduct of the office of Chief Medical Director of the Veterans Administration. To protect the quality of medical care from the machinations of politicians and bureaucrats requires the highest degree of courage and resolution; and, after longer tenure than any predecessor, you left that service in better condition than you found it.

Having thus far expressed full approval of your undertakings, I must register violent disagreement with your obvious determination to work forever. It is high time that you relax and enjoy contemplation of your many years of dedicated and distinguished service; and I wish for you another lifetime to do just this.

Sincerely,

Paul Hawley

PAUL HAWLEY

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UNIVERSITY OF WISCONSIN
MEDICAL CENTER
MADISON, WISCONSIN

Dear Bill:

The occasion of this letter gives me an appropriate opportunity to say to you that which I have not said before. You preceded me on the faculty of the University of Wisconsin Medical School by some months more than one year. This now extends to a few months over fifty years. During these years occasions and circumstances have shaped our courses in the developing program of the Medical School from a two year pre-clinical course of study to the complete four years terminating in the degree of Doctor of Medicine. Your part in this development has been not only a prominent one but a distinguished one.

Your steadfast dedication to high standards of medical education, your strict adherence to honesty of purpose and to top achievement has brought to you devotion and unanimous respect from your students and admiration from your confreres, and a host of friends and acquaintances at home and abroad.

The influence of your sincerity of purpose and skill of practice has been acknowledged as you have accepted the call to duty from patients and from your country in peace and in war.

Many honors have been bestowed upon you. Others may enumerate some of them. For me, it is a privilege and an honor to say: "Congratulations for a distinguished career—teacher, skilled physician, administrator, scholar, historian, and soldier"—and to express my admiration and affectionate regard.

Sincerely,

Bill Stovall

W. D. STOVALL, M. D.
Special Assistant to Dean

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HARVEY V. HIGLEY

MARINETTE, WISCONSIN

Dear Bill:

About ten years ago, when Admiral Joel T. Boone decided that he could not accept another term as Chief Medical Officer of the Veterans Administration, finding his successor posed a difficult task. However, when you consented to undertake that very important assignment, our worries were over. Through your years of distinguished service to humanity, in war and in peace, you were recognized throughout the medical profession, known and respected by members of Congress and the Administration, and had earned the admiration and confidence of veterans.

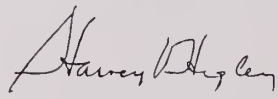
It seemed providential that a man with your wide experience and proven ability was available just when you were needed to operate the largest hospital system in the world.

I have always felt that persuading you to be Chief Medical Officer was, perhaps, my most important contribution to the Veterans Administration when I was Administrator.

Many who have been closely associated with you in various activities will bear witness to your great accomplishments. I am happy to attest to what I believe was your crowning achievement, your outstanding success during your eight years with V.A.

There will be many jewels in your crown!

Yours sincerely,



HARVEY V. HIGLEY
Former Administrator of
Veterans Affairs

A CLASS AT THE UNIVERSITY OF WISCONSIN Medical School. Recognize anyone? Doctor Middleton is in the front row standing fourth from the left.

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131. The Anemias: Their Interpretation and Treatment, 49th Ann. Meet. Hawaii Territorial Med. Assn., 1939, 11–22.
132. Some Clinical Problems in Allergy, 49th Ann. Meet. Hawaii Territorial Med. Assn., 1939, 10–18.
133. Some Pituitary-Gonadal Relationships and Their Practical Implications, 49th Ann. Meet. Hawaii Territorial Med. Assn., 1939, 12–20.
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REMEMBER DERBY DAY? The gentlemen in the derby is Doctor Middleton as he appeared in 1952. The unscheduled occasion was celebrated by Juniors at the University of Wisconsin Medical School, continuing a 39-year tradition, which provided the medical students with an opportunity to josh their professors. The devil is H. J. Fitzsimmons, Madison, about to test Dean Middleton's reflexes. The angel at the left is E. S. Sullivan, Jr., Madison.

152. Forward! University Convocation, May 8, 1946.
153. The Medical Tradition at Pennsylvania (Medical Convocation Address, March 16, 1946), The General Magazine and Historical Chronicle, 225, Summer 1946.
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225. From the Patient's Viewpoint, Pharos, pg. 3, April 1958.
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THE PRESIDENT'S PAGE . . .

W. P. CURRAN, M.D.
Antigo, Wisconsin

We Are Proud!

■ THE PEOPLE OF Wisconsin and particularly the physicians are gratefully proud that Dr. William S. Middleton chose Wisconsin as his adopted home. During the ensuing fifty-odd years he has distinguished himself internationally as an outstanding clinician, an able administrator, a medical historian, and a great humanitarian.

Doctor Middleton's influence and personal qualities in the development of the University of Wisconsin Medical School, as teacher and dean, and his outstanding administrative capabilities in the direction of the Veterans Administration are perhaps the two most significant accomplishments in his illustrious career.

His sincere interest and outstanding leadership in Society affairs are deep rooted. As deviser of the Council on Scientific Work (Commission on Scientific Medicine), and as its chairman, he contributed greatly to the postgraduate teaching programs. In 1938, Doctor Middleton was honored with the State Medical Society's Council Award, the highest award in the power of the Society. It is granted only to such as have served with distinction the science of medicine, their fellow physicians, and the public. This Doctor Middleton has done with humble greatness.

Having served in two world wars, Doctor Middleton was deeply interested in veterans affairs. In 1946 he was appointed to the Council's Committee Advisory to the Department of Veterans Affairs. As dean of the medical school, he devoted much time and energy in consultative advice to the Society.

In 1955, upon retirement as dean of the University of Wisconsin Medical School to become chief medical director of the Veterans Administration, the State Medical Society's Council passed a resolution commending Doctor Middleton "for his outstanding contributions to medicine and public health in Wisconsin."

His reputation as a medical historian is widely recognized, and he has contributed many authoritative articles to the world literature, some of which have appeared in the *Wisconsin Medical Journal.*

Although not always a resident of the state, Doctor Middleton has remained loyal to Wisconsin, continuing his membership in both the Dane county and the State medical societies. Just this year he was awarded life membership for 50 years of continuous membership.

Following retirement from the Veterans Administration in 1963 and a year as visiting professor of medicine at the University of Oklahoma Medical Center, Doctor Middleton returned to Madison and Wisconsin this summer, but not to remain inactive. He is a consultant in research and education for the VA and is state chairman of the 1965 Heart Fund campaign. But, above all, he still remains the practicing physician.

Welcome home. We are proud to have you among us.

the WISCONSIN MEDICAL JOURNAL
Published Monthly
NOVEMBER 1964
Vol. 63 No. 11

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Drugs and Ethics

■ THE SENATE ANTITRUST and Monopoly Subcommittee, headed by Sen. Philip A. Hart (D.-Mich.) recently conducted an investigation of the financial interests of physicians in pharmacies and in drug-repackaging firms. The usual charges were made that doctors who participated in the ownership of pharmacies had "a corner on his patient's dollar from cradle to the grave." But more importantly, testimony indicated that at least 5,000 doctors, or about 2 per cent of the total number of doctors in the United States, were involved in the ownership of about 100 repackaging and redistributing firms.

Senator Hart pointed out that the "true total would (not) reflect a problem of overwhelming national significance. But in various regional markets these enterprises could be extremely significant. Also, and perhaps more significant, it is a practice that appears to be on the increase."

Testimony was offered by the repackaging firms to show that even though doctors were among the owners of the firms, the doctors were too honest to allow their investments to influence their prescription of drugs.

It is curious that the subject should come to the attention of the public two years after the AMA House of Delegates and the AMA Judicial Committee had both ruled that it was unethical for a doctor to possess ownership of a drug-repackaging firm or controlling interest in a pharmaceutical company while he practiced medicine. Obviously 5,000 doctors in the United States have simply ignored the moral discipline of their profession and have continued to indulge in a conflict-of-interest situation.

Regardless of his personal integrity, the physician who owns a substantial share of the company that manufactures the drugs he prescribes for his patients exposes himself to the suspicion of working both sides of the street. And it isn't an unreasonable assumption that the doctor who can increase the return on his investment by prescribing a product in which he has a sizable financial interest will do so. The assumption is so reasonable that the AMA saw fit to go on record explicitly condemning such conflicts of interest.

For the good of the profession, such doctor ownerships of repackaging firms should be entirely eliminated. There should be no possibility of doubt that the drugs prescribed by a doctor are free of any profit to the doctor. Whether it

is so-called "good faith misbehavior" or unscrupulous gouging—and the difference may be more a matter of viewpoint than of practice—doctors should divest themselves of their holdings in repackaging firms. The integrity of the entire profession demands it.

The AMA has prohibited it, and common sense should advise against it. Yet at least 2 per cent of the doctors in the United States are guilty of the practice. Clearly, the situation calls for immediate and effective policing. The position of the AMA in the subcommittee hearings could have been much stronger if it could have adduced an example of disciplinary action taken to end such conflicts of interest. But if the AMA was against sin, in this instance, it offered little evidence that it did very much to stop it.

Since the distribution of the repackaging firms is usually of a local nature, county medical societies must bear their share of the blame for tolerating, and thus condoning, the immorality of doctor ownership of repackaging firms. A long enough "grace period" has elapsed between the condemnation by the AMA and the present time to permit what Mr. Robert B. Throckmorton, AMA general counsel, calls "severance without undue hardship." Now action is indicated—vigorous, effective, morally clean action—starting at the local level and continuing up to the AMA. The action had better start soon before the federal government does it for us.

—D.N.G.

We Remember Anna

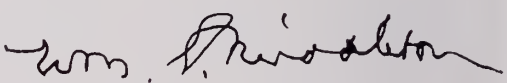
ANNA M. FRIEDRICH served the State Medical Society of Wisconsin loyally and well for 17 years. Her recent death was a loss to the administration of the Society as well as to her friends and co-workers, who will miss her smile and personal warmth.

Happily, it has been arranged that Anna's memory will continue to advance the work of the profession she assisted in her lifetime. A contribution of $1,000.00 in her memory has been made to the Society's Charitable, Educational and Scientific Foundation by her brother-in-law and sister, Mr. and Mrs. Paul E. Goetz of Milwaukee. The money will be used to help in the progress of medical science, and, eventually, to the benefit of all mankind. In the truest sense, Anna's memory will be as a blessing to all men.

The family of Anna Friedrich appreciates the great purpose of the CES Foundation; how much more so should it be appreciated by physicians and other medical personnel. It is to be hoped that the generosity and large vision of Mr. and Mrs. Goetz be emulated—and perhaps surpassed—by members of our profession so that the Foundation can continue to aid the important work being done on behalf of longer and healthier lives everywhere.

—D.N.G.

The Dean



TRIBUTE TO William S. Middleton, M.D. should properly honor his distinguished career of public service. It should mention his service with the U. S. Army Medical Corps in both World War I and II, his long tenure as dean of the University of Wisconsin Medical School, his brilliantly successful incumbency as chief medical director of the Veterans Administration, and, finally, his recently completed year as visiting professor of medicine at the University of Oklahoma Medical Center.

WILLIAM S. MIDDLETON

FESTSCHRIFT
WISCONSIN MEDICAL JOURNAL NOV. 1964

Doctor Middleton has already received many honors and tributes for his work. President Kennedy personally commended him at the White House upon his retirement from the Veterans Administration. Doctor Middleton is a past president of the American College of Physicians, the Central Society for Clinical Research, and the American Association for History of Medicine. He is a past vice-president of the Association of American Medical Colleges and the Association of Military Surgeons of the United States. He is an Honorary Fellow of the Royal Society of Medicine and the Royal College of Physicians of London and

the Association of Physicians of Great Britain and Ireland.

He is indeed a remarkable man, and the nation has much cause to applaud the activity of his lifetime. But there is more to Doctor Middleton than his work. There is the man himself—as teacher, as dean of a medical school, as practicing physician. Those of us who came to our profession in the Wisconsin medical community had an unusual opportunity to know Doctor Middleton's personality and to savor the true nobility of the man apart from his activity in the public service. It is in this, perhaps deeper, and certainly more intimate context that we offer our profound appreciation for the abiding distinction of Doctor Middleton.

As a teacher—he was professor of Medicine, in addition to being dean of the School of Medicine—he ranked with the enduringly great teachers of a great university in the days of its developing eminence. He customarily gave all the third year lectures in medicine and conducted rounds on patients in the wards. As the years went by, he gave a smaller percentage of the lectures, but teaching was then, as now, his first love. His technique was a combination of quiz and lecture, and at the end of the class period the attentive student possessed a remarkable set of notes on the subject.

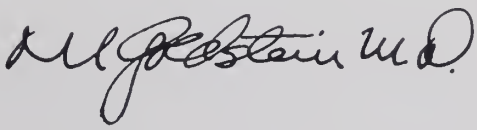
He was famous for the "brown derby" method of educational motivation. At the beginning of the junior year, the class presented him with a tan bowler. When a student answered one of his questions incorrectly, the offender was required to wear the hat during class until another student became "dunce." Each student signed the bowler on the occasion of first donning it, and by the end of the year Doctor Middleton had an autographed roster of his class. Who could forget Doctor Middleton's expression on hearing an incorrect answer—the flare of the nostril, the disdainful upward curve of the contralateral lip and the imperiously barked, "Hat!". The current wearer then sailed it through space to the new victim. The bowler never transferred for an "I-don't-know" answer, but the Dean's contempt for such a pusillanimous effort was obvious.

Doctor Middleton, as teacher, had renowned idiosyncracies. He bestowed nicknames, which more often than not stuck to the subject. The student, for example, who stated in class that drinking a quart of whiskey and a dozen bottles of beer daily was an example of "moderate" drinking, finished his academic career under the sobriquet "Vodka." The Dean had an abhorrence of seeing anyone with his hands resting in his pockets—a peculiarity he may have picked up in his military service. A student careless enough to have them there while in the hospital was liable to hear his name bellowed from afar, with the high-pitched quasi-imprecation, "POCKETS!".

Who can forget a man, a teacher, so rich in warmth, so varied, so effective in the transmission of professional instruction. Doctor Middleton is a magnificent speaker on any subject. Talking without notes or script, he was never known to have made a grammatical error; he seldom wandered, and never bored his audience. His knowledge of medical history is phenomenal, and his talks on every subject—scientific, philosophic or sociologic—were offered in the cool, reasonable light of historic perspective.

Above all, Bill Middleton is a devoted Badger—intensely proud of the great university to which he contributed so much for so long. Unflaggingly active at 74, he is alert, energetic, a fine lecturer, an astute clinician, a compleat doctor, and a great human being.

Torrents of words, printed and spoken, can convey a measure of our appreciation of his gifts. The true tribute to Doctor Middleton, however, is the deeply planted love in the hearts of the thousands of doctors who have known him, learned from him, and who will never forget him.



Minutes of Council Meeting

La Crosse, August 22–23, 1964

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:30 p.m. on Saturday, August 22, at the Holiday Inn in La Crosse.

Members present: Doctors James, Schulz, Nordby, Davis, Stoops, Kief, Dessloch (Sunday), Nadeau, Fox, Mason, Frank, Ekblad, Lee, Chojnacki, Hollenbeck, Houghton (W. J.), President Curran and Past President Egan.

Officers and others present were President-Elect Houghton, Vice-Speaker Behnke, Doctor Galasinski, AMA Delegate, Doctor Picard, Alternate Delegate, Doctor Simenstad, AMA Trustee (Saturday); Messrs. Murphy, Kluwin, Tiffany, Gill and White, consultants; Messrs. Crownhart, Ragatz, Koenig, Reynolds, Maroney; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes

On motion of Doctors Mason-Chojnacki, carried, minutes of the May 10, 1964, meeting were approved.

On motion of Doctors Chojnacki-Schulz, carried, minutes of the May 12, 1964, meeting were approved.

3. 1965 Wisconsin Work Week of Health

The program for the week is being formulated by the staff in consultation with the Executive Committee. However, advice of the Council was sought with reference to the Saturday program for officers of county medical societies. This was discussed at some length.

On motion of Doctors Kief-Nadeau, carried, the Council voted to discontinue the annual conference of county society officers.

A motion by Doctors Nordby-Stoops that as an alternative county officers be invited to quarterly Council meetings on a rotation basis, so that all would be given the opportunity in a two-year period, lost by a vote of 6–4.

4. Menominee County Survey

Doctor Nordby presented a summary report for Doctor Stuesser, chairman of the Foundation Study Committee, which stated in essence that the actual survey of health conditions in Menominee County conducted by a public health nurse has been concluded and a detailed report with recommendations is in preparation.

On motion of Doctors Egan-Hollenbeck, carried, transmittal of the formal report to the House of Delegates was authorized.

5. Commission on Hospital Relations and Medical Education

George B. Murphy, M.D., chairman, presented an oral interim report of activities of the Commission since the Annual Meeting in May, including matters which will receive further consideration before the fall session of the House and be formally reported at that time.

6. Committee on Health Economics of American Life

Chairman Fox consulted with the Council on annual appointments to this important committee which concerns itself with federal legislation of public health interest.

7. Report on Meeting of AMA Committee on Osteopathy and Medicine

The report of Doctor Frank, who attended the national conference in San Francisco on assignment by the Council, was received and placed on file on motion of Doctors Egan-Chojnacki, carried.

8. Reports to House of Delegates

Reports of the Commission on State Departments and its Division on Nervous and Mental Diseases were distributed and laid over for action on Sunday.

Mr. Crownhart reported difficulty in scheduling committee activity during the period following the Annual Meeting in May, and reminded the Council that its purpose in recommending an interim meeting of the House was predicated on a shift in emphasis on official business, through action on committee reports, from the spring to the fall. He said that in addition to the oral and written reports received at this meeting, one was anticipated from the Commission on Medical Care Plans and from the Survey Study Committee. He suggested that action taken in May to revise the bylaws making an interim meeting mandatory was perhaps premature.

9. Atmos Clock

On motion of Doctors Frank-James, carried, the Council directed a formal note of thanks to Mrs. T. W. Tormey, Sr. for the gift of an Atmos Clock in memory of her husband.

10. Reports by Consultants

Annual reports of Council-appointed consultants as to their activities and assignments on behalf of the Society were made by Messrs. Murphy and Kluwin, legal counsel; Mr. Gill, certified public accountant; and Mr. Tiffany, actuary.

11. Podiatry Suit

On motion of Doctors James-Hollenbeck, carried, the Council approved the recommendation of the secretary that the Supreme Court decision in the case of the State Medical Society v. Charles Manson, Commissioner of Insurance, be circulated to all members and to other state societies, and reprinted in the next Blue Book issue of the Journal, in recognition that it is a significant decision with respect to limited licensees in this state.

12. Appointment of Special Committee

Doctor Fox announced appointment of Doctors Blanchard, Frank, and Nordby to constitute a committee to review a complaint reported by a councilor in prior meetings.

13. 1966 Annual Meeting

The Council recessed at 4:50 p.m. to take a bus tour of facilities in La Crosse which will be utilized for exhibits, scientific and business meetings during the 1966 Annual Meeting.

It reconvened at 9:40 a.m. on Sunday, August 23.

14. Committee Reports

(a) Commission on State Departments and Division on Nervous and Mental Diseases

These reports were felt by some to be deficient in certain respects in that subjects were referred to

without sufficient detail for information of the delegates.

On motion of Doctors Kief-Egan, carried, the Council requested that they be amplified and then forwarded to the House of Delegates.

(b) Commission on Medical Care Plans

Doctor Dessloch reported orally for the Commission, which had met the prior weekend, and said that with approval of the Council his remarks would be formalized in a written report, cleared with the Commission's Executive Committee, and forwarded to the House.

In summary, the Commission will report the need to study the Wisconsin Plan and the urging of participating companies for a higher fee schedule and income level for full payment. The Commission will notify the Veterans Administration that it will not renew the home town care contract after the current fiscal year except on a usual, customary and reasonable charge basis. It is currently negotiating with the Office for Dependents Medical Care to maintain the program under the usual fee concept rather than a fixed fee schedule. The financial report through June follows the pattern of a high loss ratio traditionally experienced, and consequent reduction in reserves, but steps are being taken in consultation with the actuary and it is predicted that cause for concern will be removed by the end of the year. Contracts of Wisconsin Physicians Service are undergoing a general review and recommended revisions to improve them should be taking shape before the year end.

The Commission has met again with representatives of radiology and pathology, is sympathetic with their position and will work toward the end they desire, but WPS would be priced out of the market and its role of leadership unless all health insurance carriers did what they ask—pay for their services under the surgical-medical rather than the hospital contract. A change in these physicians' contracts with hospitals in which they practice is necessitated in any event.

On motion of Doctors Dessloch-Frank, carried, transmittal of the Commission's report, as approved by its Executive Committee, was approved.

15. Reports of Council Committees

A. EXECUTIVE COMMITTEE

The committee met Friday night, August 21, and President Curran reported the following:

(1) Appointments to Commission on Public Policy

Presidential nominees to the enlarged Commission representing each of the scientific sections were reported to the Council for confirmation.

(2) Easements to SMS Realty Corporation

The committee recommended adoption of the following resolution:

Resolved, That the Council of the State Medical Society authorize any two of its officers to execute a grant of two easements to the SMS Realty Corporation, covering Lots 14 and 15, Plat of Edgewater, Madison, Wisconsin, such lots having been purchased with WPS funds in the name of the State Medical Society, such easements to cover respectively a right of way and side yard agreement necessitated by the 1962 building program of SMS Realty Corporation on its Lakeside Street property.

(3) Amendments of Constitution and Bylaws

The committee recommended that the Council endorse the following amendments for action by the House:

Repeal of Section 3 of Article IV of the Constitution which provides for the granting of life membership upon making an outright gift to the Endowment Fund of $1,000 or more.

Amendment of Chapter XI, Section 3 of the Bylaws, adding the words "or voluntarily surrendered" to the provision that membership automatically terminates when a license has been revoked or suspended.

(4) Council Award—125th Anniversary Year

President Curran asked Council members to advise him if they have nominees for consideration.

(5) Time Schedule for Fall House of Delegates

The committee recommended the following schedule to avoid the necessity of delegates taking a week day from their practice:

Friday, October 9, dinner and meeting of Council

Saturday, October 10, first session of House at 9 a.m. and reference committees in the afternoon

Sunday, October 11, final session of House at 9:30 a.m.

Other matters reported for information were a forthcoming meeting between the Executive Committees of the Council and the Wisconsin Hospital Association; an educational program planned for the fall by the AMA was referred to the Committee on Health Economics of American Life; and the Society will not object to a rezoning petition on property in the area of its building assuming the neighbors do not object.

On motion of Doctors Egan-Nordby, carried, the above report of the Executive Committee was approved.

In addition, the committee had filed with the Council the minutes of its July 10–11 meeting, which also were approved on motion duly made, seconded and carried. These minutes follow so that formal action on various recommendations will be recorded:

(a) Actions of House of Delegates, May 1964

(a1) Resolution 30 enlarging the Commission on Scientific Medicine from five to ten appointed members

Doctor Curran consulted with the committee on nominees submitted by the Commission on Scientific Medicine, and recommended five appointees to the Council for confirmation.

(a2) Resolution 29 increasing size of Commission on Public Policy by adding a representative from each Scientific Section

This was laid over to permit consideration of the nominees by each section just received.

(a3) Recommendation by the Division on Maternal and Child Welfare that the Council initiate a study of nurse-physician relationships, especially in the area of delegated duties, with participation by the Division in such study

On motion of Doctors Bell-Van Hecke, carried, the committee recommended that the Council initiate such a study by the Division and that it be requested to secure statewide information on the problem and report its recommendations.

(a4) Resolution 16 by Survey Study Committee recommending procedures for Council meetings

In discussion of the various provisions establishing deadlines and the manner of preparation of agenda and minutes, staff participation and the like, several maintained that it is not always possible to meet state deadlines . . . emergency matters are almost certain to arise after an agenda has been prepared and up until the time of a meeting . . . it is difficult to predict how long discussion of a subject will go on . . . the resolution constitutes recommendations, not orders.

Doctors Bell-Nordby moved that the Chairman of the Council and the Secretary attempt to implement resolution 16, and such action is not intended to approve a fiscal note of $7500.

(a5) Resolution 22 by Survey Study Committee authorizing one-day symposiums on "town-gown" problems in Madison and Milwaukee

The Secretary reported that if agreeable with the Executive Committee, the Commission on Hospital Relations and Medical Education will undertake to establish this program and has indicated the wish that Doctor Houghton consult with it.

On motion of Doctors Bell-Nordby, carried, the committee approved its being conducted under auspices of the Commission on Hospital Relations and Medical Education, providing there is annual review by the Executive Committee in light of the fiscal note.

(a6) Resolution 27 amending the Bylaws to create a membership category of "Scientific Fellow"

The committee agreed that for the present there would not be active solicitation of members in this category, but as to those expressing an interest the procedure will be that they submit biographical data including educational background, affiliations, past locations, to the district councilor(s) who will make the nomination for Council election after appropriate clearance.

(a7) Resolution 37 by Milwaukee County to provide group disability coverage for all members, whether or not they be in a full dues paying classification and actively engaged in practice —referred to the Council for study and report

On motion of Doctors Nordby-Egan, carried, this was referred to the Committee on Economic Medicine for initial study.

(a8) Resolution 41 by Eau Claire-Dunn-Pepin relating to welfare payments for patients with a diagnosis of psychosis or tuberculosis

On motion of Doctors Egan-Bell, carried, this was referred to the legislative committee for study and report.

(a9) Report of Commission on Medical Care Plans with reference to Fond du Lac resolutions introduced in October 1963—referred back to the Council for further study

After discussion it was concluded to recommend that the resolutions be referred for exhaustive study, including the situation in other counties, by the Division on Public Assistance, with report back to the Council through the Commission on State Departments.

(b) Committee on Cancer Vacancy

The physician appointed by the president in May from the eighth district had since moved his practice outside the district. Action on the nominee of the Cancer Society for a replacement was tabled on motion of Doctors Nordby-Fox.

(c) Arthritis and Rheumatism Foundation

The executive office of the Wisconsin Chapter in Milwaukee had inquired whether the State Medical Society might provide telephone answering service in Madison "to give people a local opportunity to get information about arthritis and be referred to physicians when requested. Physician referrals would be handled in the usual manner. Requests for information, if seeking specific publications or information on a specific area of arthritis, could be forwarded to the Milwaukee office for follow-up."

The Secretary stated his position that an answering service in a community should be under direction of the county medical society, not the State.

On motion of Doctors Bell-Frank, carried, the request was referred to the Dane County Medical Society.

(d) State Board of Health Appointment

The State Board of Health had requested nominees for appointment of a successor to Charles W. Landis, M.D., who resigned as a member of the Medical Review Board which reviews denials of drivers' licenses by the Motor Vehicle Department to persons afflicted with epilepsy.

The Division on Nervous and Mental Diseases had recommended Francis Forster, M.D., of Madison, and he was nominated to the president of the State Board of Health.

(e) Cytology Laboratory Advertising

Correspondence with Doctor Haukohl for the Wisconsin Society of Pathologists regarding an advertisement by an Illinois physician in the Wisconsin Medical Journal was reviewed. The ad was contracted by the State Medical Journal Advertising Bureau and received in the routine of accepted advertising procedure. The Secretary interpreted existing policy of the Council as permitting acceptance of advertising by lay laboratories providing there is a medical director, and the position that advertising of a physician-operated laboratory cannot be accepted seemed inconsistent.

Doctor Van Hecke said that physician-operated laboratories in Wisconsin had agreed some time ago not to advertise, considering it unethical.

Doctor Nordby pointed out that this position could be carried to advertising of specialized hospitals which list the medical staff and this would have a serious effect on Journal revenue.

On motion of Doctors Nordby-Bell, carried, the Secretary was instructed to terminate this particular ad as soon as possible, and ask the Advertising Bureau to explain the ethical concept under which these ads are accepted.

(f) President's Council on Physical Fitness

Stan Musial, Consultant to the President on Physical Fitness, had transmitted a request that the State Medical Society co-sponsor by giving official endorsement to a regional physical fitness clinic for eight Midwestern states to be held at the University of Illinois on October 16–17, 1964.

Since an early reply was requested, the committee felt that the Council would have no objection and suggested that the Secretary inform the Council of committee approval.

(g) Council Meeting in La Crosse

Doctor Fox said that he had long tried to have the Council meet in La Crosse, and particularly in view of the meeting of the House of Delegates to be held there in 1966, he proposed to call the August meeting there. This would give the councilors and officers opportunity to see the physical facilities and offer their own suggestions.

(h) WMJ Editorial

In discussion of an editorial in a recent issue of the WISCONSIN MEDICAL JOURNAL which had provoked some comment, the committee for the most part felt that editorials such as this signed by the editorial director cannot be criticized when they are factual, even though there is not complete agreement among readers.

(i) Ethical-Legal Aspects of Compensation of Surgical Assistants in Wisconsin

Mr. Murphy had been requested to prepare a joint opinion with legal counsel of the American Medical Association as to application of Wisconsin law and ethical principles to resolutions of the Sections on General Practice and Surgery.

It was moved by Doctors Dessloch-Van Hecke, carried, that the opinion be sent to the two sections as the best legal thinking on the matter, and ask for their study and comment.

(j) Health Assistance Payments Act

The Secretary and Doctor Dessloch presented the matter of a schedule to serve as a guide to the State Department of Public Welfare in administration of HAPA. Attempts had been made to have Mr. Wilbur Schmidt come to the committee meeting, but conflicts prevented it. Various implications of the subject were discussed at length.

It was moved by Doctors Frank-Nordby, carried, that the president and chairman of the Council appoint several informed physicians to act with the staff in explaining to Mr. Schmidt the committee's thinking that it is the duty of Continental Casualty Company, the contractor, to provide the schedule to be used for auditing purposes, and the Society would be happy to review it when available.

Doctors Nordby, Dessloch and Houghton were appointed to act in the matter.

(k) Commission on Public Policy

As a matter of information, the Secretary pointed out that with action laid over on appointing section representatives to the Commission on Public Policy, it was impossible in the interim to call a meeting and have a quorum.

B. PLANNING COMMITTEE

This committee met Saturday morning, August 22, and the following matters were reported:

(1) Osteopathy

Doctor Frank summarized discussions at March and June conferences conducted on an informal basis between a subcommittee of the Planning Committee and representatives of the Wisconsin Association of Osteopathic Physicians and Surgeons. Discussion followed, after which on motion of Doctors Dessloch-Ekblad, carried, the Council approved the philosophy of the committee. Doctor Frank was asked to place in writing any specific proposals as to which he wished Council action.

(2) Alcoholism

Doctor MacCornack, author of the resolution presented to the Council in May, appeared before the Planning Committee in discussion of it, and Doctor Frank suggested that a transcript of his remarks be sent to the Council.

On motion of Doctors Nordby-James, carried, the Council approved the committee's recommendation that scientific aspects of the resolution be referred to the Council's Committee on Scientific Medicine for study before it is carried further.

(3) Medical Student Orientation Programs

Doctor Frank reported progress in the committee's study of what the Society should be doing in this area, with special thanks to Doctor Kief for his research into what is being done in Wisconsin and elsewhere. Additional research is planned by Doctor Kief and no specific recommendations were presented at this time. A subsequent report will be made.

On motion of Doctors Frank-Nordby, carried, the report of the Planning Committee was accepted as a whole.

C. ECONOMIC MEDICINE

This committee also met Saturday morning, August 22, and Doctor Nordby reported as follows:

(1) Provident Disability Insurance Program

(a) Milwaukee County Resolution 37

The committee is in accord with the advice of our insurance consultants that providing group disability coverage for retired physicians is actuarially unsound. It is an uninsurable risk and we recommend that the resolution be reported back as unrealistic.

(b) Review of Present Coverage

The committee recommends that the staff initiate a study through our insurance consultants of the possibilities of providing additional benefits in the Provident program to meet current objections, e.g., higher weekly benefit; option to select portions of the coverage; conversion privilege when moving out-of-state.

We recommend further that the total study include information on other programs available to physicians through specialty societies and the AMA.

(2) Hospital Computer Systems

The committee received a news story on the Wisconsin Blue Cross computer system and future possibilities of storing patient records for hospitals and providing direct information on medical histories through dial telephone.

Your committee believes that the matter of patient privilege should be carefully considered in connection with such future planning and suggests that this be brought up in a meeting between the executive committees of the Council and the Wisconsin Hospital Association.

(3) Travel Expenses of Employed Physicians in Emergency Calls to the Hospital

The committee recommends that correspondence between our CPAs and a member physician on the Treasury Department's denial of such travel as a deductible expense be forwarded to the AMA with the suggestion that it attempt to gather further expressions from other areas and submit them to the Internal Revenue Bureau. It is felt that there will be no reversal in the matter unless it is sufficiently challenged.

(4) University of Wisconsin Medical Center

Your committee has received some detail on expansion of the medical school facilities being recommended by a legislative committee. If approved by the Legislative Council, the proposals will be submitted to the Legislature.

We recommend that the Commission on Hospital Relations and Medical Education be asked to watch this development and interest itself particularly in the matter of future curriculum and attitudes imparted regarding medical practice.

(5) Kerr–Mills Educational Program

Referred to this committee by the Executive Committee on August 21, 1964, was a suggestion by a councilor that regional conferences be arranged to correctly explain the benefits and eligibility provisions of HAPA. It is believed that there is misinformation prevalent among some physicians, welfare

people, the public, and even Continental Casualty Company, and steps should be taken soon to clarify the matter.

Your committee recommends to the Council that the State Department and Board of Public Welfare be implored to set up county or regional forums to explain HAPA and concentrate on a uniform understanding and application throughout the state, in the interest of promoting the best utilization of the Kerr–Mills Act to the benefit of the public health.

If this is favorably received, the State Medical Society, through representatives of component county societies, will cooperate and participate in such conferences.

On motion of Doctors Nordby–Chojnacki, carried, the report of the Committee on Economic Medicine was adopted.

D. FINANCE COMMITTEE

This committee met Friday night, August 21, and Doctor Dessloch reported the following actions:

(1) 1965 Budget

It is planned that the budget for presentation to the House at the interim session show account totals only with an explanation of the kinds of expenses covered in each account. The committee will meet again on September 13 to review what is prepared by the staff.

(2) Today's Health

The committee approved a special request from the School of Education at the University of Wisconsin for a 50-copy subscription to Today's Health for students in health education, formerly provided through the Woman's Auxiliary to the AMA, and funds for which are no longer available from that source.

(3) Executive Salaries

Reported by the committee and approved in executive session were salary adjustments for several employees in an executive classification.

16. Adjournment

The Council adjourned at 11:10 a.m., Sunday, August 23, 1964.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses. (Under Revision)

6. **Find Your Future in the Health Field**
   A career guide (the health careers brochure).

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor." (Under Revision)

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **Principles for Transporting the Ill and Injured**
    A guide for providing emergency transportation services, including model community and state ordinances.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **First Aid Chart**

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

the wisconsin medical journal

VOLUME 63/NUMBER 12 DECEMBER 1964

CASE REPORT

Repair of a Congenital Diaphragmatic Hernia in a Newborn

By WILLIAM M. STOLL, M.D., Green Bay, Wisconsin

■ THE FOLLOWING presentation is the case of a newborn female, diagnosed as having a large left diaphragmatic hernia shortly after birth.

This term female infant was delivered on April 10, 1964. The infant exhibited signs of marked respiratory distress with cyanosis a few hours after birth. Physical findings indicated cardiac displacement to the right side of the chest, absent breath sounds over the left side of the chest, and decreased breath sounds over the right side of the chest. A chest x-ray film (Fig. 1) revealed abdominal viscera occupying the left side of the chest and marked displacement of the heart to the right. There were absent lung markings in the left side of the chest and marked reduction in lung markings in the right side of the chest.

The patient was seen in consultation by the author approximately 16 hours after birth and was prepared for surgery. Nasogastric suction was utilized to decompress the intestinal tract, and the patient was operated upon 20 hours after birth. The preoperative diagnosis was congenital left posterolateral diaphragmatic hernia through the foramen of Bochdalek.

A transabdominal approach was utilized. Upon entering the abdomen, it could be seen that the entire small intestine, the spleen, the right and the transverse colon and a portion of the stomach occupied the chest cavity through a posterolateral congenital diaphragmatic hernia on the left side. The viscera were reduced, revealing no hernial sac, and repair of the defect in the diaphragm was accomplished utilizing interrupted silk sutures. The defect extended medially to the hiatus and the posterior rim of the diaphragm was quite rudimentary. However, an adequate closure was accomplished. Expansion of the left lung could be visualized, but complete expansion could not be accomplished.

There was no evidence of incomplete rotation of the intestine. Closure of the abdominal cavity was accomplished with difficulty utilizing a one-layer closure of the peritoneum, posterior and anterior rectus sheaths with interrupted 4–0 stainless steel wire. The anterior rectus sheath was reinforced with additional wire sutures and the skin was closed with interrupted mersiline sutures.

Increased negative pressure was necessary to expand the left lung following surgery, and x-ray films in the operating room revealed incomplete filling of the left side of the chest with lung, but the heart was returned to the midline. A chest x-ray film, taken approximately 8 days postoperatively (Fig. 2), revealed complete filling of the left side of the chest with lung and normal location of the heart. Probably an inadequate development of the left lung was responsible for incomplete filling of the left side of the chest immediately following surgery.

Fig. 1—Preoperative view showing abdominal viscera occupying the left side of the chest and marked displacement of the heart to the right.

Fig. 2—View eight days postoperatively showing complete filling of the left side of the chest with lung and normal location of the heart.

The patient had an uneventful postoperative course and was discharged 12 days after surgery.

Discussion. Congenital diaphragmatic hernias are not common. Gross[1] reported 91 patients operated, with 76 survivals. Sixty-nine cases were of the left posterolateral type, 13 of the right posterolateral, 5 cases of the esophageal hiatus, and 4 cases of the retrosternal type through the foramen of Morgagni.

During the development of the diaphragm, there are communications between the abdominal and thoracic cavities in both posterolateral parts of the diaphragm known as the pleuroperitoneal canals. These canals are later closed by a double-layered membrane consisting of peritoneum on one side and pleura on the other side. Striated muscles soon develop between these two membranes to complete the partition between the abdominal and thoracic cavities.

If arrest in development of the diaphragm occurs before the membranes have formed, a false hernia without a sac is formed. This type without a sac occurs in approximately 90 per cent of the posterolateral hernias.

The symptoms of cyanosis and marked respiratory distress are easily related to the cardiac displacement and the marked degree of compressed lung tissue.

Immediate surgery is indicated in these patients following decompression of the intestinal tract with a nasogastric tube. The longer the delay in surgery, the more the increase in intestinal distention and the greater the difficulty in closing the abdomen. There is also danger of the blood supply to the small intestine being compromised.

The transabdominal approach affords excellent exposure, easy reduction of the viscera, and also opportunity of checking for incomplete intestinal rotation. If one is unable to close the abdomen, an incisional hernia may be created by merely closing the skin, and a second operation is performed in 10 to 14 days to correct the hernia by adequately closing the peritoneum and fascia.

Summary. The case report of a congenital diaphragmatic hernia in a newborn female infant is presented. The hernia was of the left posterolateral type through the foramen of Bochdalek. Surgery was performed approximately 20 hours after birth. Repair of

the hernia was accomplished utilizing a transabdominal approach. The entire small intestine, spleen, the right and transverse colon and part of the stomach occupied the left side of the chest cavity compressing the left lung and displacing the heart into the right side of the chest. The infant had an uneventful postoperative course and was discharged on the twelfth postoperative day.

238 Little Road.

REFERENCES

1. Gross, R. E.: Surgery of Infancy & Childhood, W. B. Saunders, Philadelphia, 1953.

OBSTETRICAL BRIEF

The Hazard of the Hysterectomy Immediately Following Cesarean Delivery

By F. J. HOFMEISTER, M.D., F.A.C.O.G.
Milwaukee, Wisconsin

HYSTERECTOMY and Cesarean section once associated only with obstetrical catastrophy, either ruptured uterus or intrauterine infection, has during the past 12 years been more frequently listed on the operative schedule of all hospitals. Still associated with catastrophy, that is mutilation of the uterus by trauma, its indications have been extended to include it as the procedure of choice instead of tubal ligation under some conditions. Its popularity was greatly enhanced following favorably reported experiences at Chicago Lying-in Hospital by Davis in 1951. Reflecting this popularity in the hospital with which the author is associated, Cesarean hysterectomy has been performed 133 times during a period when 2,218 Cesarean sections were performed for an incidence of 4.6 per cent.

However, all conditions associated with Cesarean hysterectomy are not favorable. Generalized edema of the pelvic structures associated with a coincidentally greater friability of the tissue creates one problem. The vascular areas associated with the uterus are greatly distended. Regression of the edema of the pedicles frequently results in a loosening of ligatures. Therefore this is one instance when double ligation has virtue. Distortion of pelvic structures by pregnancy adds hazard to manipulation of tissue in the proximity to the ureters. Softening and thinning of the cervix removes definitive landmarks which are essential when removing the cervix during total hysterectomy. Though supracervical or subtotal hysterectomy may at times be condoned and required, only 32 of the 133 were of this nature.

Hallett and Hirsch found that the principal complications were blood loss, bladder injury, and hematoma. Some reports indicate that total Cesarean hysterectomies require two times as many blood transfusions as do low cervical sections. That the Cesarean hysterectomy is not without hazard can be emphasized by the experiences in the author's hospital where 51 per cent required transfusion with 10 of these patients requiring more than two units and one requiring 14. This is to be compared with only 16 per cent of patients having Cesarean section requiring transfusion. There were four patients who sustained bladder injuries. All healed after primary immediate repair. No fistulae resulted.

Cesarean hysterectomy is a valuable aid when indicated. Sound judgment must be exercised when making the decision to perform this procedure, and great caution together with attention to meticulous operative technique is essential for the protection of the patient. It can not be regarded in the same category with hysterectomy uncomplicated by pregnancy.

In summary, the pelvic tissues are more edematous and the pelvic vascular system is more distended. The anatomy of the pelvis is distorted, complicating removal of the cervix and jeopardizing the ureters and bladder. Blood loss is greater and the necessity for more frequent transfusion is a reality.

2212 West State Street (53203).

SPECIAL TO THE JOURNAL

Tuberculin Reactors After Twelve Years

By C. K. KINCAID, M.D., LOUIS FAUERBACH, M.D., and E. C. NELSON, R.N.
Madison, Wisconsin

■ HOW MANY POSITIVE tuberculin reactors are there in grade one in Madison schools? How many who are negative in grade one become positive reactors by the time they reach twelfth grade? What is the percentage of positive tuberculin reactors in the twelfth grade? What is the "picture" at the ninth grade level?

These questions were studied by the Madison Department of Public Health and computations completed early in 1964. The first group was begun in 1950 and completed in 1961 (Table 1); the second group was begun in 1951 and completed in 1962; and the final group was tested in 1952, 1960, and 1963, as they were first graders, ninth graders, and twelfth graders.

TABLE 1

Fall of	Enrollment	Tested	Negative	All* Positives	Per Cent Positive
1950 Grade one	1341	1237	1216	21	1.5
1951 Grade one	1362	1054	1044	10	0.9
1952 Grade one	1672	1513	1501	13	0.86
1958 Grade nine	1449	1343	1334	26	1.9
1959 Grade nine	1475	1348	1336	25	1.8
1960 Grade nine	1675	1514	1507	25	1.6
1961 Grade twelve	1315	1123	1118	24	2.1
1962 Grade twelve	1349	1206	1200	26	2.1
1963 Grade twelve	1605	1411	1408	29	2.2

*Includes previously known positives as far as possible (Includes questionables).

The percentages in the last column of Table 1 were calculated:

$$\frac{\text{Positive tuberculin from our testing} + \text{previously known positives}}{\text{Number tested} + \text{previously known positives}}$$

Table 1 shows the results of tuberculin testing of all students who agreed and whose parents agreed to the procedure and who happened to be in that grade that year. By identifying individual students on the grade lists, one of the authors (E.C.N) developed an average of 604 "tuberculin histories" for each of the three groups and recorded what happened to their skin tests as they progressed through our public and parochial schools (Table 2).

While the total enrollment in 1950 in the first grade was 1341, over half of these students had moved away by the time 12 years elapsed. Others moved in, making the 1961 senior class enrollment 1315 which included 502 students originally present and tested as first graders and who lived in Madison twelve years.

TABLE 2

Seniors in	Neg. as 1st graders	Pos. as seniors
1961	502	2
1962	557	6
1963	754	3
Average	604	4

Method and Discussion. Health Department nurses headed by E.C.N. arranged all supplies and schedules and matched names of students on lists at each of the testing periods with the preceding lists. Nurses were responsible for cooperative planning with teachers and principals and for liaison with parents.

All testing was done in public and parochial schools in the city of Madison. A single operator (L.F.) did all the "needle work" which controls one of the variables. Material used changed half way through the study from Old Tuberculin to PPD (purified protein derivative test for tuberculosis) on a decision of our supplier. About 1960 the method of reading "positive" changed to requiring induration diameters of 5 mm. or greater. Previous to this date a few had been read as positive with less than 5 mm. induration. Another unexplored influence is the location of the student between the periods of testing: they may or may not have been continuously in residence in Madison. It is a fair assumption that most of those in Table 2 were exposed to whatever infective tuberculosis existed in this city for most of the 12-year periods.

Conclusions. In spite of these variables, we believe the results are acceptable as establishing a conversion rate (0.66 of one per cent) for this 12-year period of life in this city. Also worthy of notice is the percentage of positives in grade 12. And finally, the high percentage of senior students who submitted to a needle procedure is commendable.

Room 507, City–County Building, 202 Monona Avenue, 53709.

FOR YOUR INFORMATION . . . from the Wisconsin State Board of Health

SUGGESTED PROCEDURES FOR ROUTINE IMMUNIZATION

THE STATE BOARD OF HEALTH at its meeting on October 23, 1964, adopted the recommendations outlined below for routine immunizations. They are based on recommendations of the American Academy of Pediatrics and the Public Health Service.

The suggestions are applicable only for healthy children. Children exposed to communicable diseases and with other contraindications must follow the advice of their family physician for special protective booster injections.

DPT Immunizations

INITIAL SERIES

Children up to the age of 6 years:

The American Academy of Pediatrics recommends that the first dose be given at the age of 2 months. Children up to the age of 6 years, who start their immunizations later, follow the same schedule. *Antigen used:* Standard DPT. *Schedule:* Three injections, 0.5 cc each, one month apart.

Children between the ages of 6 and 12 years:

Antigen used: DT *"standard type." Schedule:* Two injections 0.5 cc each, one month apart. NOTE: Pertussis vaccine may cause severe reaction in children after the age of 6 years and should not be given to children over this age in immunization clinics. Children needing special protection will follow the recommendation of their family physicians.

Children older than 12 years:

Antigen used: DT *"adult type." Schedule:* Two injections, 0.5 cc per dose, one month apart.

DPT "BOOSTER" INJECTIONS

Children up to the age of 6 years:

The first booster consists of an injection of 0.5 cc of DPT one year after the initial series is finished. A second booster (0.5 cc DPT) is recommended 2 years after this injection.

Children between the ages of 6 and 12 years:

Booster consists of an injection of 0.5 cc of DT *"standard type"* to be given at 3- to 4-year intervals.

Children older than 12 years:

0.5 cc of DT *"adult type"* to be given at 3- to 4-year intervals.

NOTE: Pertussis "boosters" are omitted after 6 years of age for the reason previously stated.

Products used:

DPT—(Alum or aluminum phosphate precipitated or aluminum hydroxide adsorbed diphtheria plus tetanus toxoids and H. pertussis vaccine.)

DT—*"standard type"* (containing 5 LF diphtheria and tetanus toxoid units each per 0.5 cc)

DT—*"adult type"* (containing 1 to 2 LF diphtheria toxoid units and 5 LF tetanus toxoid units each per 0.5 cc)

Smallpox Vaccinations

The recommended age for primary vaccination for smallpox is between 6 to 8 months. Children in whom DPT and polio immunizations are started at a later age may receive their smallpox vaccination any time in the interval between the other injections. Children should be vaccinated against smallpox during the first year of life. Encephalitis is a rare complication in this age. *Re-vaccination* is recommended every 5 years, before going abroad, and in the presence of an epidemic. Hospital personnel should be re-vaccinated every three years.

Contraindications to DPT and Smallpox Immunizations

1. *Upper respiratory or other infections.* (A delay as long as 4 months is permissible between first and second injections of any series.)

2. *Infants with CNS disease with a tendency to have convulsions* should not start their injections until after the age of 12 months.

3. *Infants with eczema or other dermatitis* should not be vaccinated against smallpox.

Siblings of infants with eczema or dermatitis should not be vaccinated against smallpox unless the infant with eczema or dermatitis can be separated for ten days from the child vaccinated. *Separation means to be in different homes.* They cannot stay in different rooms of the same household. This is for the protection of the child with the skin lesion.

Measles Vaccine

Measles vaccines are not suitable for use in mass clinics. "Well baby" clinics should follow the recommendations of their medical staff.

Routine Tuberculin Testing

The Public Health Service recommends that children be tested at first entrance to school and retested at the age of 14 years. In areas of higher incidence additional screening of certain population groups is indicated.

Testing Material to be Used: Intermediate strength (5 TU) PPD intradermally. An induration larger than 10 mm may indicate recent exposure. Indurations of less than 5 mm are negative. An induration between 5 and 10 mm may be due to cross reaction from exposure to atypical bacilli or due to an old exposure to pathogenic B. tuberculosis.

Polio Vaccination

The use of oral poliomyelitis vaccine is recommended for mass programs and public health department clinics.

PRIMARY IMMUNIZATION

A. For Infants

Schedule for *monovalent* vaccines:

Type II at the time of the first DPT injection

Type I at the time of the second DPT injection

Type III at the time of the third DPT injection

Schedule for *trivalent* vaccines:

One dose at the time of the first DPT injection

A second dose at the time of the third DPT injection

In both instances a dose of trivalent vaccine is given at the end of the first year of life. The final dose in breast-fed infants should be delayed until cessation of breast feeding.

B. For All Others

Schedule for *monovalent* vaccines:

Give Type II, 8 weeks later Type I, and finally, not less than 6 weeks later Type III.

Schedule for *trivalent* vaccines:

2 doses with an 8 week interval between doses.

"BOOSTER" ORAL POLIO VACCINE

1. Children should receive a dose of trivalent vaccine at time of entry into elementary school if they had the primary series. Otherwise, the primary schedule should be used.

2. Persons at "unusual" risk, such as living in epidemic areas, traveling abroad or entering military service, need a "booster" of trivalent vaccine.

CONTRAINDICATION TO ORAL POLIO VACCINATION

None. Pregnancy per se is no contraindication. There is no need to delay a tonsillectomy, provided the child has been adequately immunized. Recent oral vaccine administration is no contraindication to needed tonsillectomy.

REFERENCES

1. Report of the Committee on the Control of Infectious Diseases, the American Academy of Pediatrics, Evanston, Illinois, 1964.
2. Report of a Special Advisory Committee on Oral Poliomyelitis Vaccine to the Surgeon General of the Public Health Service, July 17–18, 1964.

UNIVERSITY OF CALIFORNIA OFFERS TRAINING PROGRAMS LEADING TO MPH DEGREE

FOUR TRAINING PROGRAMS leading to the degree of master of public health are being offered by the University of California School of Public Health at Berkeley.

A career development program in maternal and child health has been developed and operates in conjunction with the departments of pediatrics of the medical schools of the University of California, San Francisco; Stanford University, Palo Alto; and the University of Washington, Seattle. It is sponsored by the United States Children's Bureau, which provides fellowships for the three-year program.

After its completion, the candidate will have fulfilled the training requirements for certification by the American Board of Pediatrics and also will have received the master of public health degree.

Leading to the same degree is a 9–12 months fulltime program to prepare specialists in maternal and child health. Sponsored by the U.S. Children's Bureau, this teaching program is primarily intended for physicians, but qualified members of other health professions may be accepted on an individual basis.

Emphasis is placed upon preparing the students for administrative, consultative, or supervisory positions in federal, state, local, or international maternal and child health and crippled children's agencies. Fellowships are provided by the U.S. Children's Bureau and the U.S. Public Health Service.

Inquiries for further information about the two programs may be addressed to: Dr. Helen M. Wallace, Professor of Maternal and Child Health, University of California School of Public Health, Berkeley, Calif. 94720.

Also offered is a two-year fulltime educational program sponsored by the U.S. Children's Bureau to train pediatricians to plan, direct, administer, and operate community services for mentally retarded children. The program is primarily intended for pediatricians who are certified by the American Board of Pediatrics or who meet the training requirements of the Board. Preference is given to physicians who are interested in becoming directors of community health services for mentally retarded children. Fellowships are available.

Inquiries may be addressed to: School of Public Health, Maternal and Child Health, University of California, Berkeley, Calif. 94720.

The Divisions of Maternal and Child Health, Public Health Nursing, and Health Education of the University of California School of Public Health at Berkeley offer a new 12-to-17-months fulltime program to provide intensive work in school health as a part of the general graduate preparation of public health specialists. The teaching program is intended for physicians, nurses, and health educators. Fellowships are available at the School of Public Health, funded by the U.S. Public Health Service.

Inquiries may be addressed to the Dean, School of Public Health, University of California, Berkeley, Calif. 94720.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: S. B. PESSIN, M.D.
Milwaukee, Wisconsin

Case Presentation.* A white, 47-year-old woman was admitted to the hospital in February 1962 for evaluation of rather generalized petechial hemorrhages. In 1953 the patient had a Manchester-Fothergill repair for second degree prolapse of the uterus. She complained of severe pain in the upper back which could not be explained. In October 1958 she had a hysterectomy for leiomyomas. At that time x-ray studies revealed an active ulcer of the duodenum. Laboratory examinations were essentially negative except for a slight anemia.

She had been treated with Vallestril (3-[6-methoxy-2-naphthyl]-2, 2-dimethylpentanoic acid) and dienestrol (synthetic estrogen) vaginal creme. At her last visit to the gynecologist, about five days before hospitalization, he noted the petechial hemorrhages and referred the patient to an internist. Three days before hospitalization the internist noted petechial hemorrhages and areas of ecchymosis. The capillary fragility test was positive; her hemoglobin level was 10.0 Gm. per 100 ml.; and the platelet count was 83,000 per cu. mm.

On admission laboratory returns showed a hemoglobin level of 5.2 Gm. per 100 ml., red blood cell count 1,670,000 per cu. mm., hematocrit reading 16%, white blood cell count 9,800 per cu. mm. with a differential count of 3 metamyelocytes, 6 stab forms, 54 segmented neutrophils, 33 lymphocytes, 3 monocytes, and 1 basophil. There were 4 normoblasts per 100 white blood cells. Urinalysis showed a specific gravity of 1.060, protein 2+, and red blood cells 15 to 30 per high-power field. The reticulocyte count was 8.8%, platelets 52,000 per cu. mm., prothrombin time 62%, Coombs' test negative both direct and indirect, and the stool was positive for occult blood. Blood urea nitrogen was 20 mg. per 100 ml.; serum bilirubin, direct 0.5 and indirect 3.9 mg. per 100 ml. Bone marrow revealed a marked erythroid hyperplasia and moderate number of megakaryocytes which appeared to be forming platelets. Bleeding time was 17 minutes, Lee-White coagulation time 8 minutes, erythrocyte sedimentation rate 56 mm. per hour.

The patient was admitted ambulatory with no evidence of pain or discomfort. She denied allergy to foods or drugs. There were multiple petechial hemorrhages and areas of ecchymosis. In the evening she complained of pain in the back and left arm. At midnight she complained of headache, nausea, and numbness of the left arm. The following morning she complained of headache and had an emesis. At noon she suddenly lost consciousness while sitting on the bedside. She was unresponsive for awhile and her blood pressure was 92/64 mm. Hg. (Admission pressure was 122/72). Babinski's sign was difficult to elicit. Oppenheim reflex was present bilaterally, and there was questionable nystagmus. On the same day a consultation was held with the neurologist who found the patient in a fugue state and complaining of bifrontal headaches. She was quite alert but rather weak. Kernig's sign was negative, optic fundi were normal, pupils were equal and reactive, the cranial nerves were in good order, and no sensory deficit was noted.

Subsequent laboratory reports showed a platelet count ranging from 20,000 to 26,000 per cu. mm., reticulocytes 8.3 to 14.6%, white blood cells 9,800 to 13,600 per cu. mm., increasing shift to the left involving the neutrophils, 5 to 11 normoblasts per 100 white blood cells, no LE cells, blood urea nitrogen 20 to 22 mg. per 100 ml., nonprotein nitrogen 48 mg. per 100 ml., serum carbon dioxide content 13 to 18 mEq./l., and sodium and potassium were within normal ranges.

There was evidence of slight icterus on the second day and by the third day the patient became quite deeply jaundiced. Her rectal temperature ranged from 98.6 to 105.0 F. She had periods of confusion with incoher-

* From St. Mary's Hospital.

ent speech, restlessness, and carphology. She developed hemorrhages from the gums and vaginal bleeding. The urine at this time was very dark. Petechiae and ecchymoses increased. There were increasing cerebral manifestations, such as incoherent speech and periods of stupor. Jaundice increased and there was general deterioration. She died on the seventh day of hospitalization.

Differential Diagnosis. *Dr. A. V. Pisciotta:* This was a 47-year-old woman who was admitted to the hospital because of generalized petechial hemorrhages. At the time that gynecologic surgery was performed in 1958, a routine x-ray study of the gastrointestinal tract revealed an active ulcer of the duodenum. The reason for the gastrointestinal studies is not clear except that she had unexplained pain in the upper back. Laboratory examination showed slight anemia, but no further details are given. Since she had been on Vallestril and a synthetic estrogen, there is a question of drug toxicity. Five days before she was hospitalized, petechiae and purpura were noted.

For the purpose of definition, petechiae are small pinpoint subcutaneous areas of hemorrhage, and purpura represent confluent petechiae or larger areas of subcutaneous hemorrhages which are bright red or purple in color. Ecchymoses are irregular black and blue marks which do not raise the surface of the skin. A hematoma is a hemorrhage into the muscle and subcutaneous tissue, which results in a small tumor of the subcutaneous area because of the pressure of the blood. Petechiae and purpura may be seen wherever there is vascular fragility. On the other hand, ecchymoses are particularly apt to be seen in the event of coagulation defects such as thrombocytopenia. A patient with both petechiae and ecchymoses is likely to have a low platelet count.

One can discuss differential diagnosis here from a number of aspects. Because of the prominence of the low platelet count and hemorrhagic lesions, we will first consider the possible causes of thrombocytopenia.

Platelets are made in the bone marrow from the fragmentation of the cytoplasm of the megakaryocytes. If there are no megakaryocytes in the bone marrow, thrombocytopenia would result. (Amegakaryocytic thrombocytopenic purpura). The prognosis in most of these cases is quite poor, as loss of megakaryocytes is frequently the result of aplastic anemia, leukemia, metastatic carcinoma, and the like. On the other hand, there is another large group of thrombocytopenic purpuras in which, paradoxically, the megakaryocytes of the bone marrow are actually normal or even increased in number. (Megakaryocytic thrombocytopenic purpura). It seems obvious that the cornerstone in differential diagnosis of thrombocytopenic purpura is examination of the marrow.

There are a number of etiologic factors to consider in megakaryocytic thrombocytopenic purpura. The most frequently encountered are those with no obvious cause, the so-called idiopathic thrombocytopenic purpura, or ITP. In ITP, the red blood cell values are approximately normal. The fact that this patient had severe anemia would not support the usual type of ITP.

What are some other causes of thrombocytopenia? There are those associated with an enlarged spleen, such as splenomegaly which, regardless of etiology, might adversely affect the output of the bone marrow and result in a diminution in number of elements that are ordinarily manufactured in the marrow. In cirrhosis of the liver, Boeck's sarcoid, Gaucher's disease or Banti's syndrome, where the spleen enlarges, there may be leukopenia, thrombocytopenia, and anemia. Since an increase in splenic function is implied, this is sometimes called hypersplenism. In this case we can discard hypersplenism because the spleen was not palpable, and the course of the patient's disease was fulminant.

At times thrombocytopenia might be the result of an altered immunologic reaction or auto-immune mechanism. Some patients might become sensitive to certain drugs such as allylisopropl-acetyl-carbamide (Sedormid), quinidine, or quinine. It is possible that Vallestril might have functioned in this manner, but I do not know whether this drug has been so implicated in the past. She was given salicylates for muscular pain. I am not aware that salicylates cause thrombocytopenia and anemia, although they have been implicated in bleeding due to hypoprothrombinemia.

Certain patients with infectious mononucleosis might develop thrombocytopenia. Occasionally patients with so-called autoimmune hemolytic anemia with a positive antiglobulin test might develop an antibody, with activity directed against both erythrocytes

and platelets. This is so-called Evans' syndrome, and this type of disorder usually results in combination of hemolytic disease and thrombocytopenic purpura.

Autoimmune disease may complicate the collagen disorders. We hold the opinion that the collagen diseases are themselves autoimmune disorders. It is not unusual for patients with disseminated lupus or polyarteritis to show thrombocytopenia, autoimmune or hemolytic anemia. Finally there is another disease with doubtful etiology, but probably related to the collagen disorders, and which may represent another instance of autoimmune disease. This is so-called thrombotic thrombocytopenic purpura.

What are the positive features in this patient? She had thrombocytopenic purpura and a rapidly developing anemia with evidence of erythrocytic regeneration. There were normoblasts in the peripheral blood and the reticulocytes were elevated. Normoblasts in the peripheral blood occasionally occur in metastatic carcinoma of the marrow. However, the reticulocytosis indicated that she had suddenly lost a great deal of blood, and was now compensating for the loss. Reticulocytosis is, therefore, presumptive evidence, either for hemorrhage or for hemolysis. The indirect reaction bilirubin was elevated and the marrow showed erythroid hyperplasia which support the likelihood of hemolysis, even though a fecal urobilinogen or red blood cell survival study was not done.

When she was in the hospital, she suddenly experienced headache, nausea, and numbness of the arms. She developed an indefinite and bizarre neurologic syndrome which was characterized by a tendency to clear up in one area and reappear in another. This patient shows the triad of thrombocytopenic purpura, hemolytic anemia, and transient neurologic disease as might be encountered in thrombotic thrombocytopenic purpura.

Thrombotic thrombocytopenic purpura was described for the first time in 1925 by Moschcowitz. He described the presence of thrombi in the capillaries that he thought were red blood cell thrombi. In 1935 the concept of the disease was enlarged by Baehr, Shiffrin, and Klemperer who described a number of patients with a characteristic clinical picture. Klemperer described a number of bland thrombi or occlusions of the blood vessels in which red blood cells did not participate. He thought these thrombi were composed of platelets. Since then there have been some 50 or 60 cases reported, each conforming to this type of clinical and pathologic picture.

In 1942, Altschule suggested an association between thrombotic thrombocytopenic purpura and disseminated lupus, and he was the first to suggest that this began with an alteration of the vascular endothelium.

In 1947, Orbison at Western Reserve University, made a very clever observation. He made serial sections of the blood vessels on tissue obtained at autopsy on a patient with thrombotic thrombocytopenic purpura. He then traced the outline of each subsequent serial section of an involved blood vessel by projecting its enlarged image on a piece of cardboard, cut out the tracing of the blood vessel with scissors after each blood vessel was outlined, and then reconstructed the structure of the small blood vessel which was cast in plastic. It was so demonstrated in thrombotic thrombocytopenic purpura that the blood vessel itself contains innumerable microaneurysms filled with so-called thrombi. The swollen blood vessels may readily break down to result in petechiae and ecchymoses.

The nature of the material which occludes the blood vessels is not clear. It is believed by a number of pathologists that this material represents a platelet plug, and indeed, Gore made histologic sections of fixed platelets which resembled the material present in the blood vessels in thrombotic thrombocytopenic purpura.

However, merely looking at a substance may not disclose its true nature. In this case morphology was not helpful in the evaluation of the nature of this material. Gitlin prepared an antibody to fibrin, labeled with fluorescein isothiocyanate. He found that this antifibrin fluorescent dye had a specific affinity for the material in the lumen of the blood vessels, and he suggested this was a fibrin plug that had occluded the blood vessels. The underlying physiopathology of the lesions of thrombotic thrombocytopenic purpura is still unknown. The blood vessel lesions and fibrin deposits are all similar to the experimental conditions seen in the Schwartzman reaction, and it is possible that sensitivity to an antigen not yet identified might be responsible for the lesion of thrombotic thrombocytopenic purpura.

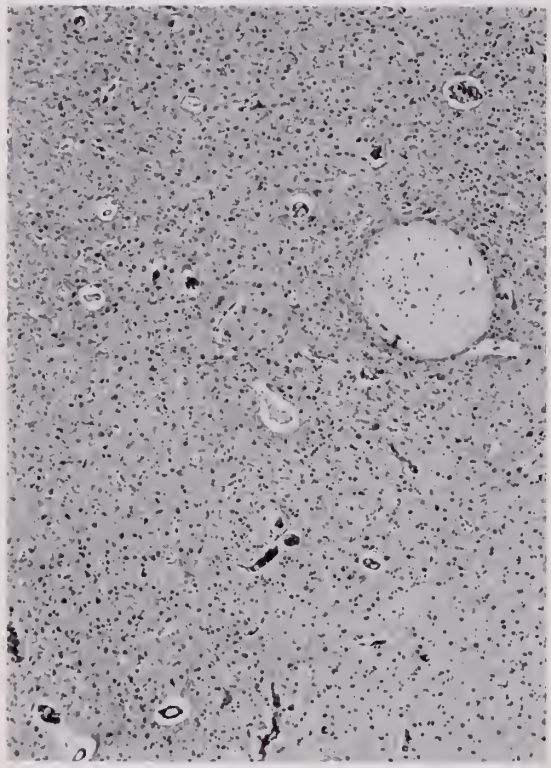


Fig. 1—Brain. Numerous thrombi in capillaries and arterioles. Round microscopic infarct in grey matter x 50.

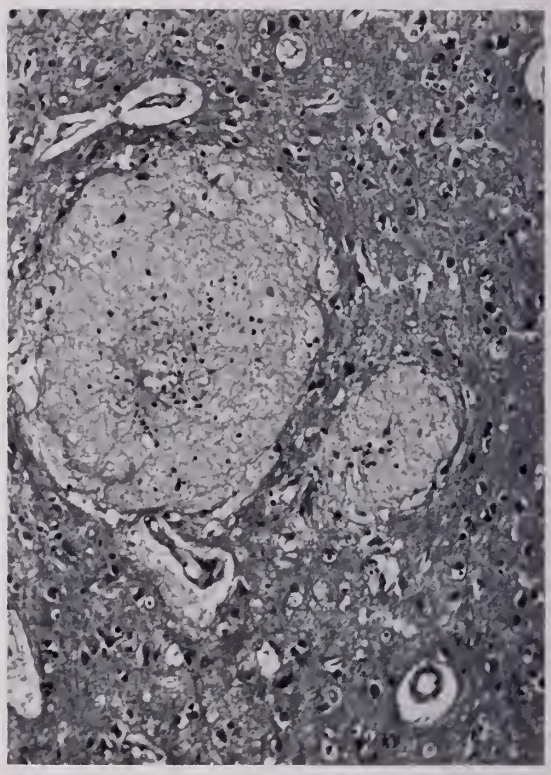


Fig. 2—Brain: Two small infarcts in grey matter. A thrombosed arteriole is present at the bottom of the large infarct x 125.

While the patient under discussion has the clinical syndrome of TTP, there is a possibility that this same syndrome may be reproduced by disseminated lupus erythematosus. We recently reported a case in the MARQUETTE MEDICAL REVIEW, which concerned a 34-year-old woman who was admitted to the hospital because of severe, rapidly developing anemia with hemoglobinuria, thrombocytopenic purpura, and transient focal neurologic disturbances. She had several negative lupus erythematosus cell preparations. Coombs' test was negative. However, a hemolysin was found, and red blood cell survival time was markedly diminished. On these grounds the diagnosis of thrombotic thrombocytopenic purpura was made.

The patient was treated with cortisone and testosterone simultaneously and went into an excellent remission which lasted five years. At this time her clinical picture, blood cell count, platelet count, and red blood cell survival time were all within normal limits. Because she was getting along so well we thought we would gradually wean her from corticosteroids. About ten days later she developed extreme malaise and myalgia. At this point the LE preparation was now found to be strongly positive.

In our patient, the clinical picture which was so similar to that of thrombotic thrombocytopenic purpura actually represented classic lupus erythematosus. The question to be answered is whether thrombotic thrombocytopenic purpura is basically the same as disseminated lupus erythematosus.

Pathologic Discussion. *Dr. S. B. Pessin:* The post mortem revealed the characteristic changes of thrombotic thrombocytopenic purpura. Grossly, there was moderate icterus of the skin and conjunctiva. There were numerous petechiae involving the skin of the entire body except the face, and a few areas of ecchymoses. Small hemorrhages were present in the buccal mucosa. About 1,000 ml. of dark amber-colored fluid was present in the abdominal cavity, 1,000 ml. of serosanguineous fluid in both pleural spaces, and about 100 ml. in the pericardial sac. There were cardiomegaly (440 Gm.), splenomegaly (450 Gm.) and hepatomegaly (2,450 Gm). Petechial hemorrhages were present beneath

Fig. 3—Heart: Longitudinal section af arteriale distended with a thrombus. Note the cross sectian of the some arteriole about 1 cm. belaw and in line with the langitudinal section of this vessel x 50.

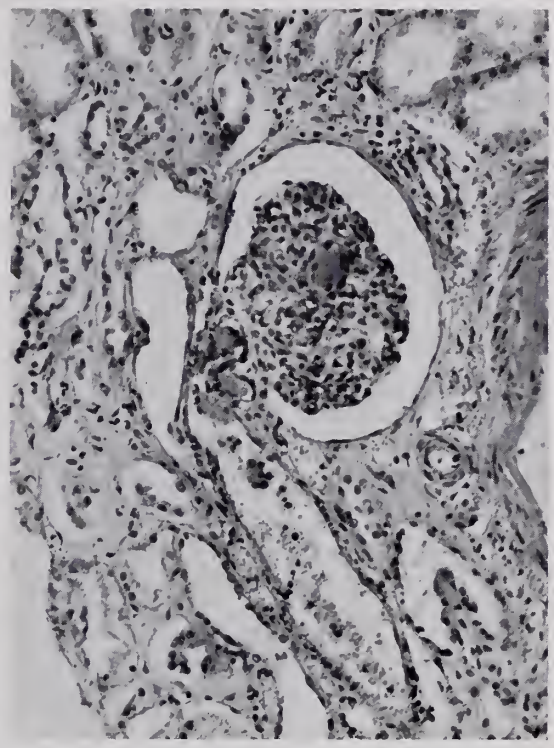


Fig. 4—Kidney: Thrambus in glamerulus and efferent arteriole x 125.

the epicardium and endocardium, cortex of both kidneys, gastric mucosa, and brain. A small chronic ulcer was present in the first portion of duodenum.

Microscopic examination revealed thrombosis of capillaries and arterioles of the myocardium, brain, liver, kidneys, pituitary gland, lymph nodes, pancreas, and bone marrow. The brain was extensively involved and revealed, in addition to numerous thrombi in the capillaries (Fig. 1), small hemorrhages and microinfarcts. The small hemorrhages were in the grey and white matter. However, the numerous microinfarcts involved only the grey matter (Figs. 1 & 2). Numerous thrombi were present in the capillaries and arterioles of the myocardium (Fig. 3). Thromboses in the kidneys and liver were less in number than in the brain and myocardium. Most of the thrombi in the kidneys were found in the glomeruli (Fig. 4). Many sections were prepared for the purpose of searching for thrombi in prearteriolar vessels, formation of aneurysms, and necrosis of vessel walls, all of which have been reported. None of these changes were recog-

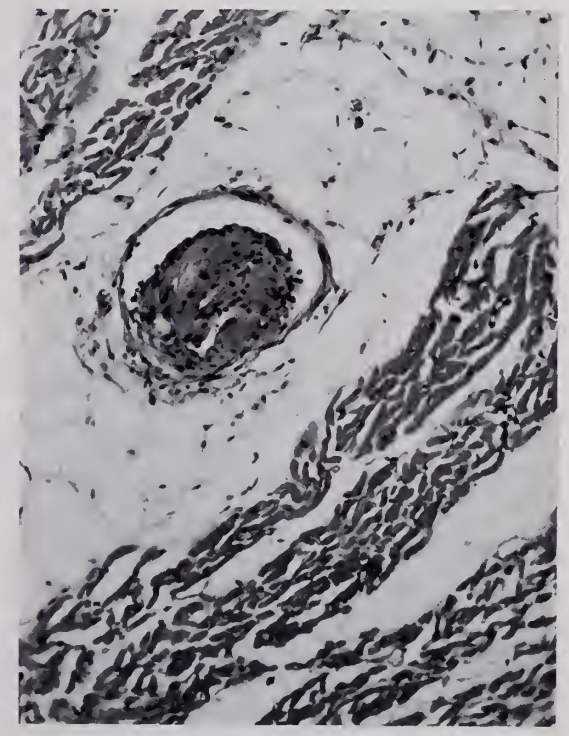


Fig. 5—Heart: Endothelial cells line the intraluminal projection thrombus x 125.

nized. There was a suggestion that the earliest lesions consisted of endothelial swelling and subendothelial fibrin deposit. As this pink staining fibrin or clot enlarged, it projected into the lumen. Some of these intraluminal projecting thrombi were lined by endothelium (Fig. 5).

There is very little to add to Doctor Pisciotta's excellent discussion of thrombotic thrombocytopenic purpura. These patients die of extensive tissue destruction and hemolytic anemia.

Dr. Maurice Hardgrove: Do these thrombi originate beneath the endothelial lining? Are all of the thrombi lined by endothelium?

Doctor Pessin: The thrombi originate at the site of injured endothelium, but I am not absolutely certain that the thrombi develop beneath the endothelium. Some sections revealed subendothelial pink staining substance which I interpret as fibrin. Many projecting thrombi are covered by endothelium but the majority are not. Perhaps the older thrombi are endothelialized, and those that are not may represent propagating thrombi.

Doctor Hardgrove: Should thrombotic thrombocytopenic purpura belong to the group of collagen diseases?

Doctor Pessin: I believe it is an autoimmune disease. I did not find vasculitis or fibrinoid necrosis of vessel walls which is present in some collagen diseases such as in systemic lupus erythematosus, periarteritis nodosa, and others.

Doctor Hardgrove: Does this disease have remissions?

Doctor Pessin: Cases have been reported with remissions and perhaps complete recovery. These cases were proved by lymph node biopsies. I might mention that skin biopsies have proved unsatisfactory. The skin sections in our case revealed no thrombosis. Thrombosis of capillaries is frequent in lymph nodes. The case which Doctor Piscotta has reported is rather convincing of remission and perhaps related to lupus erythematosus.

Dr. S. A. Spicuzza: What happens to the platelets?

Doctor Pessin: They are apparently utilized in the formation of thrombi. The majority of investigators still believe that initially platelet thrombi are formed. Doctor Pisciotta mentioned that Gitlin has convincingly demonstrated that with fluorescent fibrin antibody technic he has proved the thrombus is positive for fibrin. Platelet antibodies labeled with fluorescein isothiocyanate, the same fluorescent substance tagged with fibrin antibody, failed to react with platelets. Nevertheless, this does not prove that the nucleus of the thrombus is not composed of platelets. We know that platelets contain fibrinogen, one substance in the formation of fibrin. Fibrin therefore collects on the platelets and thus yields fluorescence with the antifibrin fluorescent technic. In addition to your question, other problems remain unsolved. We do not know the cause of the severe hemolysis and why thrombosis occurs only in the capillaries and arterioles but not in the small and medium-sized arteries.

2320 North Lake Drive.

EDITOR'S NOTE: Doctor Pessin passed away Nov. 9, 1964, before this article could be published.

PAMPHLET ON FAMILY PLANNING

The idea of having children by choice instead of by chance is more widely accepted today than ever before. For all religious creeds there are acceptable methods of family planning to guarantee each child his "first birthright—to be wanted."

A NEW CHAPTER IN FAMILY PLANNING, a Public Affairs Pamphlet just released, discusses the latest developments in both attitudes and in methods. The pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. Author is Elizabeth Ogg, who has also written other popular Public Affairs Pamphlets on family relations, psychology and mental health.

PAMPHLET ON TEETH

For the more than a hundred million American children and adults suffering from untreated tooth decay and other serious dental and oral diseases, there is much helpful advice in KEEPING YOUR TEETH HEALTHY, by Judy Graves. This is a new Public Affairs pamphlet, available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

BABIES AND CHILDREN have a greater chance to live into adulthood: Since 1930, the death rate for babies under one year has dropped 63%; for children one to four years, 82%; for children five to fourteen years, down 76%. New drugs have helped substantially in bringing this about.

THE PRESIDENT'S PAGE . . .

W. P. CURRAN, M.D.
Antigo, Wisconsin

With the Christmas Season upon us, it is my sincere wish to all of you, for the blessings of the Great Physician, who is with us at all times, may He continue to watch over all of us in the coming year.

the WISCONSIN MEDICAL JOURNAL
Published Monthly
DECEMBER 1964
Vol. 63 No. 12

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Last Chance

■ PRESIDENT JOHNSON'S landslide victory last November 4th foreshadows what will probably be the finally successful effort to legislate Medicare. The Democratic platform promised a tax-supported medical program for the aged, and the dominantly Democratic constitution of both the new House and the new Senate makes it inevitable that the opponents of Medicare will be swamped next time the issue comes up.

The proponents of Medicare came within a squeak of carrying their program last Congress. It was only Representative Wilbur Mills of Arkansas, guarding the solvency of the entire social security system like Horatio at the bridge, who stopped a legislative flanking maneuver by relying on his prestige in the House. The Senate had already voted Medicare; it was only in the House that the Administration failed to muster the votes that would have compelled a conference compromise putting the program into effect.

If the Administration presses for passage in the first weeks of the new Congress, as can be expected, the seven year battle will be lost, and the nation will be embarked on a new experiment that most of the medical profession believes will result in inequities, injustices and an inferior quality of medicine for certain categories of citizens.

While the prospect for opposing Medicare is bleak, it is not altogether hopeless. President Johnson's support, by its very massive character, implies a coalition. And coalitions have a habit of falling apart after a brief "honeymoon." If the Administration delays its push for Medicare until after more pressing legislation is passed, it is possible that the anti-Goldwater conservatives will re-group in opposition to the Administration. If that happens, Representative Mills may again save the day.

It must be recognized, however, that Medicare can't be permanently stopped by a series of legislative holding actions. Tax-supported medicine is a vital concept with all the characteristics of a progressive social advance. It also has the advantage of being the only medical program for the aged that offers the possibility of uniform, universal consistent application. To our own shame, the medical profession has offered little to oppose it except statistics and high sounding moral principles.

Painful as it may be, we must face the fact that Kerr–

Mills medical assistance programs do not provide the kind of protection against ruinous medical care costs that senior citizens with reduced incomes believe they need. For whatever reason, Kerr–Mills aid is not available in all states, and where it is available, it is often grossly inadequate to the realities of chronic illness. Despite the growing number covered by it, medical insurance for the elderly is extremely costly and, in most cases, its benefits are limited.

Prior to the last election, the American Medical Association engaged an advertising agency to launch a nationwide "educational" program to convince the public that existing health care mechanisms for the aged were adequate and that no new tax-supported schemes were necessary. Instead of accomplishing its purpose, the AMA's program seemed to underline the fragility of the position of the medical profession on this important issue. Its timing suggested support of the Republican candidate instead of concern for the people, and its slick air of self-righteousness emphasized the case-worker approach of the Kerr–Mills plans.

What the opponents of Medicare clearly need is a new idea around which to rally. The new idea must be as universal as Medicare, more adequate than Medicare, but as independent as an insurance program. It must be a reasonable, humane, dignified approach that preserves the basic relationship between doctor and patient without abridging the freedom of the former to practice nor of the latter to select.

Medicare can be permanently defeated with a sound, medically sponsored concept that confronts the problem of health care for the aged with honesty—one that furnishes a workable solution to the problem of assuring the elderly that they won't become public relief cases in the last years of their lives. It is time for the medical profession to realize that the popularity of Medicare does not result from a lack of "education" on the part of the public and that its proponents are not wild-eyed radicals intent on bankrupting the public treasury. Medicare is popular because it promises reasonable, understandable help to many people to whom the need of obtaining medical care is much more urgent than the morality of the method of obtaining it.

The medical profession has not yet found a workable alternative to Medicare. If Medicare is to be defeated permanently—not just stalled from one Congress to the next—an alternative must be offered quickly. And if the best we can produce to oppose Medicare is a mish-mash of statistics, principles and poor-house-type assistance, we thoroughly deserve Medicare.

—D.N.G.

"Tommy" Hendricks . . . A Loss Deeply Felt

THE DEATH OF Thomas A. Hendricks four days before the November 8 meeting of the North Central Medical Conference in Minneapolis was deeply felt by members who adopted a resolution expressing their great sorrow. The State Medical Society of Wisconsin, one of the members, shares the sentiments expressed in the resolution which follows:

WHEREAS, Thomas A. Hendricks, whose sad passing occurred in Chicago last week, attended every session of this conference which did not represent an irreconcilable conflict in dates, and

WHEREAS, "Tommy" Hendricks, as he was known to everyone associated with medicine all over this country, was the close personal friend of nearly every member of this conference,

BE IT THEREFORE RESOLVED, That the North Central Medical Conference express its great sorrow at his passing, and the profound sense of loss felt by its members who are present here today, and

BE IT FURTHER RESOLVED, That a copy of this expression be sent to his daughter, Mrs. Robert Hollowell, and to other members of the bereaved family.

Mr. Hendricks, who died November 4 in Chicago at the age of 72, had been a medical society executive for nearly 40 years. He was assistant to the executive vice president of the American Medical Association and a

member of the AMA staff from 1946 to 1963. At the time of his death he was assistant to the executive vice president of Continental Casualty Company.

A native of Indiana, he was executive director of the Indiana State Medical Association from 1924 to 1946, and served in the Indiana state legislature from 1933 to 1941. He joined the AMA in 1946 as secretary of the Council on Medical Service, and later was field director of the association. He retired from the AMA in 1963.

What IS Your State Medical Journal?

THE WISCONSIN MEDICAL JOURNAL is the *official* publication of the State Medical Society. In this capacity it publishes the transactions of the meetings of the House of Delegates and the Council as well as the reports of major committees of the organization. In its unique annual Blue Book edition are published current medico-legal and socio-economic matters and a roster of the entire State Medical Society.

It is a *scientific* publication that carries four or five original papers every month. It is *not* a repository for second class articles or those rejected by national journals. It does not publish all articles submitted to it, as the rejection rate averages 25% annually. It does encourage young or "first-time" authors, even though their maiden efforts may require extensive editing, or may consist of a single case report. Conversely, an article is not automatically accepted simply because it originates in a teaching or metropolitan medical center. Frequently the articles published have particular application to the state of Wisconsin.

It is a *method* of disseminating a monthly medical-mental exercise, the CPC, which is not a common feature in state medical journals.

It is an *archive* and a chronicle of medical news. This begins by listing new licentiates and news of physicians beginning their practices. It continues with their noteworthy medical activities and terminates with their obituaries.

It is utilized occasionally as a *special way* to pay tribute to an outstanding medical individual or institution. Most recent examples were the Doctor Stovall and Doctor Middleton *Festschrifts* and the Marquette University Medical School golden anniversary issue.

It is, through its "Comments on Medical Treatment," a *means* of reproducing condensed, authoritative, current therapy. This has traditionally been written by members of the pharmacology departments of the two medical schools in the state.

It is in *competition* with a plethora of postgraduate courses, professional films, tapes and TV and hundreds of medical journals. The other journals may be national, local, specialty or controlled circulation. These may be colorless or glossy with a spectrum of color—but they are numerous. The journals are all competing for advertising revenue, and some of the state medical journals are in varying degrees of acute and chronic advertising anemia. A few years ago the WISCONSIN MEDICAL JOURNAL had what some readers considered excessive advertising pages, although there were no complaints about the revenue resulting to the State Medical Society. Now, because of the Kefauver investigation and the FDA restrictions, there has been a sharp decrease in new pharmaceutical products. This, coupled with the tremendous increase in controlled circulation (free) journals, has drastically curtailed the income from advertising.

The WISCONSIN MEDICAL JOURNAL is a *bonus* to members of the State Medical Society. We believe it does justify its continued existence. In striving for excellence, we need your help. In this issue is a questionnaire having two objectives. One objective is to obtain information that will enable the staff to produce a better journal with the type of scientific articles the readers want and whatever special features are desired. The second objective is to attract more advertising through an improved journal. A good response will indicate the importance of your own state medical journal.

—V.S.F.

Doctor: We Urgently Need Your Opinion!

It is of considerable importance to your *Journal* that the following questionnaire be completed, removed from your journal and mailed to your state medical society as shown below. We urge you to take just a moment for this task, with the assurance that your effort will help us produce a better journal for you.

1. My chief professional interest is
   general practice ( ) or specialty _____

2. I rate the scientific papers in
   (name of your journal) as:
   ( ) Excellent ( ) Fair ( ) Poor

3. I read the *pharmaceutical* advertising in the journal:
   ( ) Regularly ( ) Sometimes ( ) Rarely

4. I have referred to the *local* advertising in the journal:
   ( ) Often ( ) Sometimes ( ) Never

5. Please give the name of *one* local service, firm or institution (professional or commercial) which you have referred to, or purchased from, as a result of seeing its advertising in your journal:

_____

6. Please list the professional journals you read in order of preference. (You may show your opinion of your state medical journal by its position on this list.)

   1. _____ 4. _____
   2. _____ 5. _____
   3. _____ 6. _____

7. When examining your journal do you more often read papers by authors or from hospitals with which you are *personally* familiar, than articles from other sources? ( ) Yes ( ) No

8. What feature do you like best
   in your journal? _____

9. What do you like least? _____

10. What is missing that you would like added? _____

_____

_____

_____

PLEASE TEAR OUT AND RETURN TO:

STATE MEDICAL SOCIETY OF WISCONSIN

BOX 1109 • MADISON, WISCONSIN 53701

WISCONSIN POSTGRADUATE PEDIATRIC SEMINAR

"The Importance of Immune Mechanisms in Clinical Pediatrics" will be the subject of the annual postgraduate seminar of the University of Wisconsin Department of Pediatrics April 1–3, 1965, in the Wisconsin Center building at the University of Wisconsin, Madison.

The faculty will include Dr. Clark West, professor of pediatrics, University of Cincinnati; Dr. Ralph Wedgewood, professor and chairman, Department of Pediatrics, University of Washington; Dr. Richard Smith, professor and chairman, Department of Pediatrics, University of Florida; and Dr. E. Richard Stiehm, fellow in pediatrics, University of California. Members of the Wisconsin faculty participating include Dr. Oliver Smithies, professor of medical genetics; Dr. Robert Auerbach, professor of zoology, and members of the Department of Pediatrics.

The seminar will provide basic information on the nature and genesis of immune mechanisms, their importance in the production of disease and use in its prevention. Teaching will include lectures, panel discussions, and small discussion groups.

The seminar is open to all physicians. Registration fee is $50. Address inquiries to: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison, Wis. 53706.

MD'S TO SEE CONTINUING MEDICAL EDUCATION PROGRAMS VIA OPEN CIRCUIT TELEVISION

Early next year approximately half of the physicians in Wisconsin will have an opportunity to view four half hour television presentations for continuing medical education on sets in their own homes.

The Commission on Scientific Medicine of the State Medical Society, in cooperation with the University of Wisconsin Medical School and the Marquette University School of Medicine have produced four half hour experimental television programs, scheduled to be aired over the educational stations in Madison and Milwaukee the latter part of January and early February. It is estimated that half of the physicians in Wisconsin will be able to receive the programs.

Dealing with four completely diverse subjects, the programs are experimental in nature insofar as this will be the first opportunity Wisconsin physicians will have to view and evaluate such material via open circuit television. In prior experiments with medical television in Wisconsin, closed circuit facilities have been specially arranged.

In an effort to discourage "lay viewing," a concern during the planning sessions, it was arranged that the television stations will sign off the air at their usual times, then come back on the air ten or 15 minutes later to present the program.

Physicians in the viewing area will be notified several days in advance of the time, channel and station. The notification will also contain a return postal card for evaluating the material and production.

Open circuit teaching programs have been a decided success in such diverse areas as Utah and New York City. More recently a triple-state arrangement was made by the University of Pittsburg School of Medicine, telecasting to Pennsylvania, Ohio and West Virginia.

The Wisconsin series, titled "TV Medical Seminar," studies four unrelated subjects.

The first, on "Iron Deficiency Anemia," is conducted by two Marquette University men, Dr. Anthony Pisciotta, Associate Professor of Medicine and Dr. Ennio Rossi, Assistant Professor of Medicine and Director of the Department of Hematology of the Milwaukee County Hospital.

" 'Diagnostic' Features of Rheumatoid Arthritis," the second program, was prepared by and features two University of Wisconsin men, Dr. John Juhl, Professor of Radiology and Dr. Murray Angevine, Professor of Pathology.

Third in the series is on "Deafness In Early Childhood" and is conducted by Dr. James D. Cherry, Assistant Professor of Pediatrics at the University of Wisconsin Medical School and Claude Hayes, Ph.D., Professor of Speech and Associate Director of the Speech and Hearing Clinic at the University.

The fourth and final program of the experimental series is jointly conducted by Dr. Edward J. Lennon, Dr. Jacob Lemann and Dr. Joseph Beres, Associate Professors of Medicine at Marquette and is titled "Acute Renal Failure."

REPORTS AND TRANSACTIONS OF 1964 INTERIM SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin
OCTOBER 10, 1964

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REPORTS PRESENTED TO THE HOUSE OF DELEGATES AT THE INTERIM SESSION

State Medical Society of Wisconsin October 10, 1964

The Interim Session of the House of Delegates of the State Medical Society of Wisconsin was held at the State Medical Society headquarters in Madison, Wisconsin, October 10, 1964.

Presented below are reports submitted to the House. Following these reports is the Transactions of the House which includes the recommendations of the reference committees and the House actions on these reports.

■ REPORT OF COMMISSION ON STATE DEPARTMENTS—OCTOBER 1964

T. W. TORMEY, Jr., M.D., Madison, Chairman
L. M. Simonson, M.D., Sheboygan, Vice-Chairman
A. M. Hutter, M.D., Fond du Lac
H. A. Anderson, M.D., Stevens Point
J. W. Nellen, M.D., Green Bay
John R. Evrard, M.D., Milwaukee
Charles A. Wunsch, M.D., Green Bay
H. W. Carey, M.D., Lancaster
Paul A. Dudenhoefer, M.D., Milwaukee
Richard B. Windsor, M.D., Sheboygan
James C. H. Russell, M.D., Fort Atkinson
Meyer S. Fox, M.D., Milwaukee

This report to the House of Delegates at its interim session is intended to inform and bring before the legislative body of the Society those items of concern not reported at the Annual Meeting in May. Thus, it is necessarily a brief report inasmuch as the interim period is short, and the time of year is not particularly conducive to a heavy schedule of meetings due to vacations and related summer activities. The Commission has not been dormant, however, and its annual reorganization meeting in June was well attended.

At its first meeting following the Annual Meeting of the House of Delegates, the Commission invites each of the state department directors involved in the health field. This is an important meeting and is intended as a two-way affair in which the state agencies are asked to bring before the Society projects, problems and questions which involve the health care of the state. The Commission brings to the state department directors its interests in the same subject, with a common goal of mutual understanding and cooperation between voluntary organized medicine on the one hand and government administered programs on the other. It is through this mechanism that the solutions to many of Wisconsin's health problems have been found in the past, and we hope many more in the future.

It is axiomatic today to state that government has an extremely large stake in the health care field. One need only glance at statistics to see the extent of this interest. During the fiscal year 1962–63, public assistance alone, through the State Department of Public Welfare and the county welfare offices, paid over $33 million to health care vendors. This was an increase of 11.5 per cent over the previous fiscal year. (It should also be noted that physicians received only 9 per cent of that amount.) When added to the programs of the State Board of Health, the State Board of Vocational and Adult Education and the State Department of Public Instruction, the size of these programs in dollars and cents is substantial. Of more obvious importance, however, are the results to the recipients of care.

Except for county hospitals and homes, these programs are almost totally dependent on private sources of care—practicing physicians, general hospitals, private nursing homes, etc. It therefore becomes doubly important that the relationship between the private sources of service and the government agencies providing payment for the services be one of close communication and cooperation. Where problems arise, and they do, it has been found that the best means of resolving them is between the agency involved and the appropriate representatives of the Society. In each of the ten Divisions there is sufficient depth of experience and knowledge to arrive at recommended solutions in the particular area of interest delegated to that Division involved. As its name implies, the Commission works with state agencies and where problems involve county agencies they are best handled by the local county medical society.

The State Department of Public Instruction has several projects on health which it is conducting, including one on smoking and youth, and one on sports for girls. The Department has requested more vigorous support of athletic programs by local medical societies and the Division on School Health will be working with that Department on the possibility of either a one day program on the subject at the next Annual Meeting or some other positive means of initiating greater interest in this area.

The State Department of Public Welfare is very much involved in the comprehensive mental health planning activities and will be putting a great deal of time and effort in the area of mental health. The report of the Division on Nervous and Mental Diseases points out its interest in this area. As a part of this subject the Department is concerned with the implementation of Bill 170, S., passed by the Legislature in the current session. This bill changes the state reimbursement formula to county mental hospitals and provides an incentive to these institutions to develop acute treatment programs and facilities, rather than the present custodial type of program prevalent in most county institutions.

The State Board of Vocational and Adult Education is greatly concerned at the present time over the schedule of fee allowances for physicians doing examinations for the Board in its disability determination program. This problem was brought before the House last May in the report of the Division on Rehabilitation and steps are being taken to arrive at a new revised schedule for use by the Board.

The following are reports of some of the Divisions' activities:

DIVISION ON AGING

The Division on Aging has before it several current problems relating to improvement of the custodial and convalescent facilities now available. With a nursing home accreditation program now a reality, emphasis will be placed on encouragement of homes to meet those standards. Although a great deal of discussion has preceded the program adopted by the National Council for the Accreditation of Nursing Homes, there is still no widespread acceptance of it across the state. A voluntary group in Wisconsin is still working on a set of standards which it apparently intends to sponsor in this state only. The Division has previously recommended the concept of uniform nationwide standards and this has been approved by the Council. In this same area of concern the Division will be following with interest the progress of nursing homes in complying with the new regulations adopted by the State Board of Health. The Division is pleased that one of its

members, Dr. George G. Stebbins, Madison, was a member of the committee which helped prepare these new regulations. Other subjects which the Division will take up include health insurance for the elderly and a forthcoming publication of the National Council on Aging entitled "Principles and Criteria for Determining Medical Indigency."

DIVISION ON CHEST DISEASES

While this Division has not been able to meet since the May 1964 meeting of the House there are several matters which are being considered, and will be reported as soon as possible.

Resolution 25, which would require the State Board of Health to inform a person screened for TB or associated chest conditions that his subsequent examination would be by a private M.D. and a charge made for such service, has been discussed with the State Board of Health, and it is anticipated that changes to accomplish the goal of the resolution will be made. A full report on this will be provided the House in May, 1965.

The Division is pleased to report that an increasing number of counties have requested the screening program of the State Board of Health to include "associated chest conditions," and a few counties, *at the request of the county medical society*, have included diabetes testing as part of the screening program. As mentioned in previous reports, the Division requests counties *to have a member of the State Board of Health staff explain the expanded screening program*, and methods of working with family physicians in follow-up, before making a decision as to whether or not to utilize the screening services of the State Board of Health. Only through full understanding of the services available can members of the county medical societies determine whether such services are of value to them and their patients. Having the State Board of Health staff member explain the program does not in any manner obligate the county society to accept the services available, in whole or in part.

The Division continues to study the patient load in institutions caring for the tuberculous patient, and will keep the House informed if the situation changes to suggest either an expansion or contraction of current facilities.

The Division is aware of the efforts of WATA to affect a "total eradication" program in selected areas, and if the Association selects areas for further pilot studies it is urged that physicians cooperate in any manner suggested.

DIVISION ON HANDICAPPED CHILDREN

This Division, acting in an advisory capacity to the Bureau of Handicapped Children of the Department of Public Instruction, has been in close touch with Dr. Patricia McIllece, Medical Advisor of the Bureau, on all problems of a medical nature which are associated with various programs relating to handicapped children. Most of the programs are of long standing, and have been thoroughly reviewed and reported on to the House in previous years.

1. The orthopedic clinic program is being conducted along lines which the House has approved, and are being offered only in counties which have requested the service through the county medical society. This past year one county, Sheboygan, which had dropped out of the program has again requested service.

2. The Bicillin program, previously reported to the House, has been turned over to the State Board of Health, so that the program could be continued for patients beyond their 21st year, which is the limit of service available through the Bureau for Handicapped Children. Procedures and methods of reporting established by the Bureau and approved by the House through reports of the Division are being followed, so this service to physicians should be continued in accordance with previous actions of the House.

3. A pilot program of assistance to families particularly hard hit, financially, through having children with cystic fibrosis has been conducted, but no conclusions on this have been reported to the Division. Cases qualifying for assistance are restricted to those recommended by the family physician, so there should be no objection on the part of the House on this experimental program.

4. The Bureau is deeply concerned with the problem of the child requiring special medication having this administered at the school, either by a nurse or therapist, without specific instruction from the attending physician. Usually these drugs are brought to the school by the child himself, sometimes with or without a note from the parent, and the Bureau is concerned that some improper administration of the drug might result in a fatality, with resulting suit directed to the school, the therapist, or the nurse. This matter has been referred to the Commission on State Departments, but to date no definitive action has been taken. It is hoped that prior to the May, 1965 meeting of the House some recommendations on this subject can be transmitted from the Division.

DIVISION ON MATERNAL AND CHILD WELFARE

It is anticipated that this Division will meet before the House convenes, but it is unlikely that a specific and full report can be made until May of 1965. However, the House might well be aware of projects which are engaging the attention of the Division members.

The Maternal Mortality Study continues as approved by House action, and the Study is being made the basis of various teaching programs. This past June the Bureau of Maternal and Child Health of the State Board of Health requested the Study Committee to offer a one-day teaching program for osteopaths in Milwaukee. This matter was cleared through the Council, and with Council approval, presented. More than half of the osteopaths in Milwaukee County and surrounding counties were in attendance, and all expressed appreciation that the benefits of this research project of the State Medical Society could be made available to them. It is anticipated that similar programs will be presented in the future, if such is the desire of the osteopaths and the State Board of Health.

The special training of obstetrical nurses for small hospitals, approved by House action, and being conducted under the auspices of Marquette University School of Nursing and the Bureau of Maternal and Child Health of the State Board of Health, is being continued, and is serving a valuable objective. The 24 hospitals which have participated in the program to date have been most enthusiastic. The medical staffs of the hospitals served have participated in the training program and seem well pleased with the results.

The Division has, since last reporting to the House in May 1964, concluded its special teaching programs in "Care of the Newborn." The entire series of meetings, concluded with conferences in New Richmond, Superior and Antigo in June, served 99 Wisconsin hospitals, and attracted a total of 653 persons, which included 112 M.D.'s, 399 hospital nurses, and 45 public health nurses.

In its May 1964 report to the House the Division suggested having created, through the Council, an ad hoc committee to discuss the responsibilities (and limitations) of nursing services in hospitals and doctors' offices. This has been approved by the Council, and the special committee is being formu-

lated. It is hoped that at least a preliminary report on this can be presented to the House in 1965.

Other matters before the Division are suggestions that the "Child Abuse Law" be amplified, and that compulsory testing of phenylketonuria be enacted into law. The Division has not had time to study these two subjects thoroughly, but will make appropriate recommendations to the House in May 1965, or to the Council if action before that date seems indicated. From preliminary study it does not appear desirable to materially change the present law in relation to reporting of cases involving child abuse by parents or others; nor does it appear desirable to make testing of PKU a matter which becomes a *compulsory* obligation of physicians. Historically no programs which require compulsory reporting achieve results comparable to voluntary programs, backed by good education to the physicians of the state. However, this subject will be studied further by the Division, and a more concise statement will be made to the House in May.

DIVISION ON PUBLIC ASSISTANCE

The Division on Public Assistance has received the resolutions introduced into the House of Delegates in October, 1963, on the subject of welfare health care programs, by action of the Council. This subject had been before the Commission on Medical Care Plans because of the request that such programs be changed to a mechanism involving insurance company administration of claims such as the Wisconsin Kerr–Mills program and a report was made by that Commission in May. The Council has referred the subject to this Division for study because of the growing number of requests from county medical societies for assistance in the area of fee schedule negotiations and other agreements concerning patient care. The Division on Public Assistance has also been asked to discuss the subject of prescriptions for welfare patients for other than covered medications. Another subject referred to the Division involves preparation of a chart describing each of the various government health care programs, benefits provided, eligibility, etc. This chart would show the distinction, for example, between the Health Assistance Payments Act and the health care benefits provided recipients of Old Age Assistance.

The Commission is pleased to announce the following appointments to the Divisions and to thank the physicians whose terms are expiring for their time and efforts on behalf of the State Medical Society:

Division on Aging:

S. E. Sivertson, M.D., La Crosse—reappointed
W. C. Kleinpell, M.D., Kenosha—reappointed
George W. Shinners, M.D., Green Bay—reappointed

Division on Chest Diseases:

B. R. Lawton, M.D., Marshfield—appointed
W. J. Little, M.D., Racine—appointed
R. H. Wasserburger, M.D., Madison—appointed

Division on Handicapped Children

Lloyd P. Williams, M.D., Appleton—reappointed
Robin Allin, M.D., Madison—reappointed
Ray R. Rueckert, M.D., Portage—appointed

Division on Maternal and Child Welfare:

F. G. Johnson, M.D., Superior—reappointed
G. H. Stevens, M.D., Wausau—reappointed
M. J. Olson, M.D., Monroe—appointed
K. F. Pelant, M.D., Grafton—appointed

Division on Nervous and Mental Diseases:

Henry Veit, M.D., Milwaukee—reappointed
Edward E. Houfek, M.D., Sheboygan—reappointed
J. T. Petersik, M.D., Oshkosh—reappointed
G. B. Tybring, M.D., Madison—reappointed

Division on Public Assistance:

C. A. Olson, M.D., Baldwin—reappointed
W. W. Meyer, M.D., Medford—reappointed

Division on Rehabilitation:

Louis Kagen, M.D., Milwaukee—reappointed
R. E. Housner, M.D., Richland Center—reappointed
James F. McDermott, M.D., Wauwatosa—appointed

Division on Safe Transportation:

George Anderson, M.D., Stevens Point—reappointed

Division on School Health:

E. E. Bertolaet, M.D., West Allis—reappointed
Rolf F. Poser, M.D., Columbus—appointed

Division on Visual and Hearing Defects:

Richard J. Fogle, M.D., Racine—reappointed
James V. Bolger, Jr., M.D., Waukesha—reappointed
John B. Hitz, M.D., Milwaukee—reappointed

The state agencies are represented on the Divisions by the following individuals, who are appointed by the respective department director:

State Board of Health:

Mr. Paul Fleer—Divisions on Aging and Rehabilitation
Josef Preizler, M.D.—Division on Chest Diseases
James L. Wardlaw, Jr., M.D.—Divisions on Maternal and Child Welfare, Nervous and Mental Diseases and School Health
Miss Helen Callon—Division on Maternal and Child Welfare
Arthur L. Van Duser, M.D.—Division on Safe Transportation
Mr. Oscar R. Cade—Division on School Health

State Department of Public Welfare:

Mr. T. J. Lucas, Sr.—Divisions on Aging, Public Assistance and Visual and Hearing Defects
Mr. Frank Newgent—Division on Maternal and Child Welfare
Robert O'Connor, M.D.—Division on Maternal and Child Welfare
Leonard J. Ganser, M.D.—Division on Nervous and Mental Diseases
John R. Allen, M.D.—Division on Public Assistance
Mr. E. L. Hoskins—Division on Rehabilitation

State Department of Public Instruction:

Patricia E. McIllece, M.D.—Divisions on Handicapped Children and Visual and Hearing Defects
Mr. John Melcher—Divisions on Handicapped Children and Visual and Hearing Defects
Mr. Orlo Miller—Division on School Health

State Board of Vocational and Adult Education:

Mr. A. E. Towne—Division on Rehabilitation
Miss Beatrice Palen—Division on School Health

State Motor Vehicle Department:

Mr. John Thompson—Division on Safe Transportation

In addition to the above, Weston C. Tormey, D.D.S. is a special consultant to the Division on Rehabilitation and many other representatives of state agencies are called upon as special items are taken up by the Divisions.

■ REPORT OF DIVISION ON NERVOUS AND MENTAL DISEASES of COMMISSION ON STATE DEPARTMENTS —OCTOBER 1964

Charles A. Wunsch, M.D., Green Bay, Chairman
A. A. Lorenz, M.D., Eau Claire, Vice-Chairman
Edward E. Houfek, M.D., Sheboygan
J. T. Petersik, M.D., Oshkosh
G. B. Tybring, M.D., Madison
Henry Veit, M.D., Milwaukee
Jean P. Davis, M.D., Milwaukee
Keith M. Keane, M.D., Appleton
T. J. Nereim, M.D., Madison
Otto A. Dittmer, M.D., Ripon
Francis M. Forster, M.D., Madison
William H. Heywood, M.D., Marshfield
Walter J. Urben, M.D., Madison

Since the Division made an extensive report to the House in May, this report is in the way of supplementary information on subjects introduced since that time as well as continuing projects.

The Committee on Commitment Laws is continuing with its activity in the preparation of proposed legislation directed toward control of the "dangerous offender." Meetings have been held with judges and other knowledgeable experts in the field and a draft has been prepared for preliminary discussion and review by the State Department of Public Welfare. The proposed measure is taken from a model sentencing act prepared by an advisory committee of judges to the National Council on Crime and Delinquency. In essence this proposal permits the judge to sentence a convicted felon who meets the definition of a "dangerous offender" up to 30 additional years. This is consistent with the Division's belief that such individuals typically lose their potential for acts of violence with age.

The subject of registration of psychologists was before the Division at its last meeting, after being referred there by the Council for recommendations on the medical aspects. The Council adopted a statement on compulsory registration or licensure which was reported to the House in May, 1963. In essence, the Council statement recommends voluntary certification and opposes further extension of licensure, certification or registration of ancillary health personnel under Wisconsin law. Although the psychology association sponsored legislation last year to provide for certification under the law, there was disagreement among the psychologists themselves as to its desirability. The bill was defeated but the proponents may try again in the next session, although the psychology association has just recently announced a voluntary program of certification. There is no reason to doubt the efficacy of the Medical Practice Act in preventing the unlawful practice of medicine and the flagrant violators can and will be stopped.

We note that the problem is broader than the practice of clinical psychology alone and feel it is so important to the health of Wisconsin's citizens as to warrant a thorough analysis. It should be pointed out that the dividing line is often very thin, since it is recognized that not only psychologists are involved but also social workers, nurses, ministers, vocational counselors, teachers, etc. With increasing emphasis on good mental health the public will not only become more cognizant of the problems of the mentally handicapped but will seek and demand more services and care. As this demand becomes more acute physicians must not only be prepared to treat those needing care, but there should be some means of assuring that services are being rendered by competent ancillary personnel with either medical supervision or sufficient training to recognize their limitations.

The Division was requested to consider, at its last meeting, the rule presently followed by the Motor Vehicle Department in requiring that an epileptic be seizure free for two years before a license can be issued. This rule was suggested by an advisory committee of the State Medical Society several years ago and has worked with apparent success. There is provision in the law whereby an applicant whose license is denied on these grounds may have review by an advisory committee of physicians if he feels the two year period is too strict. After review and discussion the Division decided the present rule is a fair standard based on scientific information and is a reasonable period. In doing so it noted that in many states which license epileptics the requirement is an even longer period of time.

The Commission on Medical Care Plans asked the Division to consider the subject of adequate insurance coverage of nervous and mental illnesses. This was taken up at the last meeting and the Division notes that concern in this area is a sign of increased attention to the responsibility of private resources in the payment for care of mental illness. Discussion of the subject pointed up many problems in coverage of such illnesses: recognition by the insurance industry of the trend toward shorter lengths of institutional care; greater advances in recognition, diagnosis and cure; development of governmental institutions into active treatment centers rather than custodial facilities; definitions of terms to obtain a clearer understanding of what ailments are included such as personality disorders, senility or arteriosclerosis in old age, alcoholism and drug addiction; and recognition by the insuring organizations of the relationship between mental and physical illnesses. At present WPS defines "illness" in the majority of its policies to include nervous and mental disorders as well as physical disorders, but further defines "nervous or mental disorders" as "any condition classified as a neurosis, psychoneurosis, psychopathy or psychosis." This distinction is made in order that a limitation may be placed on "nervous or mental disorders," especially in benefits for institutional care. Generally such benefits are reduced from a maximum number of days per admission to a maximum for the life of the contract, and under one policy the benefits for care in sanitaria are restricted to patients transferred from a general hospital. The Division recommends to the Commission on Medical Care Plans the following:

1. The use of deductibles or co-insurance;
2. That coverage be on the basis of service rather than diagnosis; and
3. That a psychiatrist be asked to meet with the Commission on Medical Care Plans as an adviser to it.

The Division's proposed programs on psychiatry for the general practitioner have been outlined and financing obtained but the response by local chapters of general practitioners has been disappointing. Interest has been shown in two areas of the state, but in others the proposed program did not receive much enthusiasm. It was intended from the beginning that the programs be held only in areas where local support is found. The Division noted the success of the program on Depression, held in Eau Claire last April, and based on the past excellence

of these programs the Division recommends the proposed program on "The Adolescent," tentatively planned for early spring of next year in Eau Claire, to the Commission on Scientific Medicine.

Another subject taken up by the Division is the matter of reports to physicians by state hospitals on discharged mental patients. There is general recognition by the State Department of Public Welfare's Division of Mental Hygiene, of the need for a better reporting system, but the many problems involved in achieving it are equally well recognized by the Division. It was pointed out, for example, that often the institution does not know who the family physician is, especially on involuntary commitments. Also, the state hospitals receive requests for reports from judges, social workers, guidance clinics and other interested persons, thus increasing the burden. The Division is fortunate in not only having a state hospital superintendent as a member but the advice and cooperation of the Director of the Division of Mental Hygiene as well. It is hoped that future exchanges of ideas will assist in finding new approaches and the Division of Mental Hygiene has been asked to develop further solutions to the problem.

The Division continues to follow quite closely the activities of the State Comprehensive Mental Health Planning Committee and reports are made at each meeting by the State Medical Society representatives.

The Division is pleased to learn of the appointment by the Governor of Max M. Smith, M.D., Madison, to the State Mental Health Advisory Committee. It is hoped that Doctor Smith may be able to attend meetings of the Division in order that matters of mutual interest can be communicated effectively.

The Division warmly commends H. Kent Tenney, M.D., Madison, former Chairman of the State Mental Health Advisory Committee, for his outstanding leadership and efforts in bringing about a greater public recognition of the need for good mental health.

The Division has submitted a list of names of interested persons to the American Medical Association for invitations to the Second National Congress on Mental Illness and Health. This Conference will be held in November of this year, in Chicago, and representatives of the Division will be in attendance and on the program. The first Congress was held in October 1962, and was considered very successful in implementing the AMA's mental health programs. The forthcoming Congress will provide a forum for the exchange of ideas and experiences, and a chance to assess progress and attack problems.

The Division has again considered the subject of the Interstate Mental Health Compact, introduced into the Legislature last year as Bill 167, S. and indefinitely postponed. At the time that Bill was under discussion various amendments were introduced to strengthen the civil rights of patients. With those amendments, requiring notice to patients and relatives and other guarantees, the Division finds the compact is in the best interests of mentally sick people. Among other things, the compact permits persons needing care to receive it in any contracting state regardless of his residence, settlement, or citizenship and the patient may, when there are clinical factors indicating his care and treatment would be facilitated or improved, be transferred to any other contracting state. The Division sees little logic in requiring a Wisconsin citizen who becomes ill in another state to remain institutionalized in that state solely because his residence had been established there, if that patient's condition could be improved or better treated in Wisconsin where his family and friends may be near. The law places no such restrictions on persons physically ill and the distinction does not appear warranted. It is our recommendation, therefore, that support be given this measure, with the safeguards referred to above, if it is re-introduced in the 1965 session of the Legislature.

■ REPORT OF COMMISSION ON MEDICAL CARE PLANS—OCTOBER 1964

E. M. Dessloch, M.D., Prairie du Chien, Chairman
Robert Krohn, M.D., Black River Falls, Vice-Chairman
R. S. Baldwin, M.D., Marshfield
Charles Benkendorf, M.D., Green Bay
G. W. Carlson, M.D., Appleton
W. T. Casper, M.D., Milwaukee
M. D. Davis, M.D., Milton
Milton Finn, M.D., Superior
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
Donald A. Jeffries, M.D., Shawano
P. B. Mason, M.D., Sheboygan
Howard Mauthe, M.D., Fond du Lac
A. J. McCarey, M.D., Green Bay
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
J. T. Sprague, M.D., Madison
A. H. Stahmer, M.D., Wausau
F. H. Wolf, M.D., La Crosse
W. P. Curran, M.D., President, Antigo
J. H. Houghton, M.D., President-Elect, Wisconsin Dells

The second interim meeting of the House of Delegates presents an opportunity to report results of the first half of the current year compared with the prior one.

Benefit Utilization

A 15½ million dollar premium income objective is well on its way to being realized. Earned premiums of $8,694,609 through July, 1964 were $1,233,964 higher than for that same period of 1963. With the second half of the year traditionally producing more income than the first, our estimated goal is within reach for 1964.

Along with income, subscriber benefit payments are up too. Subscribers are using their coverage at a more rapid rate than in 1963. This has resulted in our paying out almost 94 cents of each earned premium dollar in benefits during the first seven months of 1964.

Recent trends in the utilization of health care benefits in all Blue Plans point sharply upward in most categories. These trends are general, and seem to be due to factors not responsive to short-range control. WPS has installed rate adjustments to continue to maintain the sound balance vital to its future responsibilities.

This increase in benefit payments is best demonstrated by our growing volume of claims handled each month:

Average Number of Claims Per Month	*First Half of Year* 1963	1964
From Physicians	10,610	12,815
From Hospitals	2,977	3,493
Combined	13,587	16,308

Our contract count increased too! The total went up almost 8,300 with 6,000 of these carrying Major Medical coverage as well as base benefits. At the same time as these Special Service (no fee schedule) contracts were being sold, the outstanding "B" Schedule contracts were being upgraded. The "B"

Schedule is no longer in the WPS sales portfolio for groups or individuals, except those over 65 years of age.

Promotion

WPS continues to keep its name and services before the public through advertising in newspapers and magazines. Increased emphasis was placed on cooperative advertising with our 200 sales agents in local newspapers and over local radio stations, intended to reach that segment of the small town and rural market which we are progressively developing.

A large direct mail promotional campaign based on the theme of "Tickets to Protection" will be underway this fall. It is designed to acquaint Wisconsin people with WPS and its health insurance programs. During this campaign we will be reaching into more than a half million Wisconsin homes and telling our story via direct mail.

Dental Benefits

Marketing of a Dental Contract was initiated during early 1964. A direct mail program to presently enrolled groups evidenced much interest in dental insurance. However, there is much spadework to be done to acquaint employers and the public with the benefits of this type of coverage. Since WPS is among the first to attempt to market a comprehensive dental benefit in Wisconsin, we may well have to continue to research before finding the type of contract people "desire" or "need" most to buy. Dentists are being included in our mailings in order to keep them informed of our activities, and an advisory committee of the Wisconsin State Dental Society provides liaison to the Commission.

Senior Citizens

The Society's concept of providing health care to senior citizens through private initiative is receiving accelerated impetus and attention. Sales and promotional plans always include Century Plan emphasis. The number of Century Plan contracts in force increased more than 12 per cent from June 1963 to June 1964. We had 13,629 contracts in force at the end of July. Increasing numbers of employers are continuing to cover retirees under their group contracts as well.

General Contract Revision

The Commission has instructed staff to prepare revised contract documents for its review during the year. The revision is intended to update the benefits contained in WPS contracts.

New Computer System

The first six months of 1964 saw the culmination of many months of work and planning in the preparation of material to be stored in the 1440 IBM Computer. More information now recorded and processed by hand is being readied for Computer application. Much has been done but much more will be done to utilize fully the nearly limitless capacity of the Computer concept.

Radiology and Pathology

The Commission has met with representatives of the practice of Radiology and Pathology. It continues to try to find a solution to their desire to be paid direct and have their services carried only in that portion of *all* insurance contracts applicable to physicians' charges. For *only* WPS to make such contract change—and rate adjustment—would not solve the problem. Such a solution would only make WPS noncompetitive in the market place with all other insurors who did not revise their contracts to pay only a physician's billing for radiology and pathology. Patients receiving a bill from a hospital for these services would want that bill paid.

The Commission concludes that medicine as a whole must support these two specialties in their attempt to practice medicine as we all wish to—as independent private practitioners, billing a fee for service to those we treat. The solution will not come from insurance contracts; it must come from those practicing in these specialties.

Medicare

The Office for Dependents' Medical Care presented requests for adoption in Wisconsin, North Dakota, and Minnesota, of a fee schedule of allowances to replace the present concept in these states of the payment of usual, customary and reasonable charges. As negotiations have continued, the prior contract has been extended three times in 1964, now through January 31, 1965, without change. The Commission, charged with the responsibility for administration of this program, met with representatives of the Office for Dependents' Medical Care and presented Wisconsin's position—a fee schedule is unacceptable!

Two hundred sixteen thousand dollars in payments have been made to Wisconsin physicians during the first half of 1964 under the Medicare program. This is about equal to the same period of 1963.

Veterans Administration

The existing contract with some upward adjustment in fees was signed to implement the Veterans Home Town Care Program for another year. However, with Council approval the Commission will notify the Veterans Administration that next year the only acceptable basis for negotiation will be the usual, customary and reasonable fee concept.

HAPA

The Kerr–Mills program began operations about a month ago. The Commission is watching results with interest and attempts to alert the Council of developments. Since WPS is not a party to that contract, the Commission does not become involved in its administration except to the extent that helpful suggestions can be provided the State Department of Public Welfare.

Conclusion

The Commission continues its efforts to look to the future so it may be ready when medical, social, technological, yes, even political breakthroughs occur which affect the WPS product and market. This continued awareness of coming events keeps WPS alert to its avowed purpose of being the pioneer in health care coverages.

■ REPORT OF THE COUNCIL—OCTOBER 1964

The Council met in May following adjournment sine die of the House of Delegates, and at that time the structure and operation of the Society were reviewed in detail through the presentation of slides and the opportunity to ask questions. The chairman of the Council, James C. Fox, M.D., of La Crosse, was reelected as was the vice-chairman, John M. Bell, M.D., of Marinette. Also reelected was the secretary, Mr. C. H. Crownhart, all of these elections having been postponed by Council action at the time of its March 1964 meeting.

Certain other routines were transacted at this time, and the Council approved a request by the Section on Ophthalmology and Otolaryngology, presented by Doctor Nadeau, that it affiliate with the National Medical Foundation for Eye Care.

Normally the midyear meeting is held late in July, but this was postponed until August 22 in order to give the Council opportunity to comply with

the request of the House of Delegates that it review committee reports six weeks before the scheduled meeting of the House. There were few available at this time, but other important matters were before the Council.

General approval of the Council was given to the format for the 1965 Wisconsin Work Week of Health, which is under the more immediate supervision of the Executive Committee, but in discussion of the fact that there are two sessions of the House together with the Work Week of Health, the Council voted to discontinue the annual conference of county society officers in 1965.

There was preliminary review of the report coming to the House on the Menominee County health problems, and transmittal to the House was authorized upon its completion.

The Council directed a formal note of thanks to Mrs. Thomas W. Tormey, Sr., of Madison, widow of the late T. W. Tormey, M.D., who died in 1942, for the gift of an Atmos Clock in memory of her husband.

A progress report was filed with the Council relating to the work of the Commission on Hospital Relations and Medical Education, and reports of the consultants to the Society, Messrs. Murphy and Kluwin, legal counsel, Mr. Gill, certified public accountant, and Mr. Tiffany, actuary, were received.

The Council at this time noted the Supreme Court decision in the case of the State Medical Society vs. Charles Manson, Commissioner of Insurance, and because of its great importance authorized its circulation to all members of the Society and to other state societies, and its periodic reprinting in the Blue Book issue of the Journal as a significant decision with respect to limited licensees.

The Council heard reports of the Commission on State Departments and one of its divisions, that on nervous and mental diseases, and with some clarification directed that they be forwarded to the House. It received an oral report of the Commission on Medical Care Plans and directed that when prepared in written form, and having been cleared with the Executive Committee of the Commission, it be forwarded to the House.

The meeting was held in La Crosse in order to permit councilors and officers to see the facilities that would be available for the 1966 meeting, and to be in a position to advise with the staff as plans proceed in that respect.

President Curran reported proposed appointments to the enlarged Commission on Public Policy and Commission on Scientific Medicine, and one or two vacancies on committees, and the Council approved the appointments as offered.

In addition, a number of resolutions acted upon by the House of Delegates in May were on the Council agenda, with the following action taken.

Resolution 16 recommending procedures for Council meetings was discussed at length and the chairman of the Council and the secretary were directed to attempt to implement the resolution but without the expenditure of any additional funds.

Resolution 22 authorized symposiums on Town-Gown problems, and this was assigned to the Commission on Hospital Relations and Medical Education for implementation, with the Council directing that there be a review of these programs annually for the purpose of determining effectiveness and costs.

Resolution 27 creating a membership category of scientific fellow was discussed with the decision being reached that there should not be an active solicitation, but those expressing an interest in affiliating in such fashion be asked to submit biographical data which would be forwarded to the appropriate councilor for consideration and report to the Council as a whole.

Resolution 37 relating to group disability coverage was referred to the Council's Committee on Economic Medicine, which reports its intent to make a comprehensive study of the entire program with report back to the Council at a later date.

Resolution 41 relating to welfare payments for patients with a diagnosis of psychosis or tuberculosis was referred to the Commission on Public Policy for study and report.

The resolutions of Fond du Lac County, first introduced in 1963, referred to the Commission on Medical Care Plans and reported back in May of 1964, were re-referred by the House to the Council for further study. The Council determined that these resolutions more appropriately should have been assigned to the Commission on State Departments and its Division on Public Assistance. This has been done and it is hoped that a report will be available to the House no later than May.

Advertising policies of the Wisconsin Medical Journal were reviewed and miscellaneous matters not involving policy but details were discussed. Among these were proposals relating to expansion of medical school facilities in Madison, and this subject was assigned to the Commission on Hospital Relations and Medical Education to watch developments and to interest itself particularly in the matter of future curriculum and attitudes imparted regarding medical practice.

The Council received reports relating to studies of alcoholism and medical student orientation programs which indicate that satisfactory progress is being made in carrying out efforts in these various fields.

The Council is meeting Friday night prior to the interim session of the House of Delegates and it is anticipated that a supplementary report will be available when the House convenes on Saturday. The Council transmits two resolutions, numbers 13 and 14, both of which are self-explanatory.

JAMES C. FOX, M.D., Chairman of the Council

RESOLUTION NO. 13

Introduced by: The Council, October 1964

(This resolution providing an amendment to the Constitution cannot be acted upon until the May 1966 meeting and is merely introduced at this time.)

Resolved, That Section 3 of Article 4 of the Constitution, reading as follows, be repealed:

> "Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society."

EXPLANATORY NOTE: This section was enacted in the late 30's when the Society contemplated the establishment of an Endowment Fund. Such action was not taken, there is no Endowment Fund, and consequently the section should be repealed in the interest of clarity.

RESOLUTION NO. 14

Introduced by: The Council, October 1964

Resolved, That Chapter XI, Section 3, paragraph two, of the Bylaws be amended by adding the underlined words:

> "A member of a component society whose license has been revoked, suspended, *or voluntarily surrendered*, shall be dropped from membership automatically as of the date of revocation, suspension, *or voluntary surrender*. The Council of

the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council."

EXPLANATORY NOTE: While the Council believes that the only interpretation to the Bylaws of the Society is that one must hold a valid license to be a member, it nevertheless recommends the amendment as a constant source of authority for this construction.

SUPPLEMENTARY REPORT OF THE COUNCIL (A)

In reference to Resolution No. 12 offered by the Dane County Medical Society, the Council at its meeting last night reviewed the resolution in light of the statement made by it in 1954 relative to the qualifications of a Dean then under selection. It feels that the resolution would be better stated if it cited the long interest of the State Medical Society in this subject and the responsibility of its membership in the matter.

A substitute resolution was presented by Doctor Nordby, and the Council forwards it to the House for reference to the Committee on Resolutions as more appropriate to the particular circumstances with which we are now confronted. The substitute resolution follows:

WHEREAS, The State Medical Society of Wisconsin, in accordance with Article II of its Constitution, has among its purposes, in existence for 123 years, the extension of medical knowledge and advancement of medical science and to elevate the standard of medical education; therefore be it

Resolved, That the Dane County Medical Society encourage the State Medical Society to join in support of efforts to obtain a Dean of the University of Wisconsin Medical School who is a physician experienced in the provision of medical care in the environs of a teaching hospital, who might be expected to emphasize the educating of clinical physicians for the State of Wisconsin while encouraging the continuation of significant research among those so talented, and opportunities for postgraduate and refresher courses; and be it further

Resolved, That the Council of the State Medical Society of Wisconsin make known to the Board of Regents of the University of Wisconsin the support of the State Medical Society in these views.

SUPPLEMENTARY REPORT OF THE COUNCIL (B)

In May of 1963, this House approved a statement on osteopathy. In the judgment of the Planning Committee of the Council, this statement needs elaboration in some respects and being submitted to you, with the recommendation of the Council, is the Planning Committee's report, with a proposed news release and other matters relating to this subject.

Subject: Osteopaths and Postgraduate Training
Report of Planning Committee of the Council

This report is concerned only with the subject of those holding the academic degree of Doctor of Osteopathy and Surgery, and licensed in Wisconsin to practice medicine and surgery. It directs attention of the Council to the Statement of Policy on the Relationships between Doctors of Medicine and Doctors of Osteopathy, adopted by the Council in February 1963, and having the concurrence of the House in May 1963. A complete copy is attached (see Exhibit 1 below).

In substance, this stated circumstances under which voluntary relationships with osteopaths would not be considered unethical, and indicated plans of the State Society to encourage such Doctors of Osteopathy as meet these qualifications to attend appropriate programs of postgraduate education. Doctors of Medicine may address groups of osteopaths as well.

While many societies approved local osteopaths for participation in maternal mortality study programs, this action was not broad enough to include their listing for other types of programs.

In June 1964, with approval of the Council, the Maternal Mortality Study Committee, appointed through mechanisms of the Commission on State Departments, at the request of the State Board of Health did provide a one-day teaching program for osteopaths in Milwaukee and surrounding counties. More than half of the potential were in attendance, and expressed appreciation that the benefits of these studies were being made available to them.

Further training of osteopaths meeting the qualifications established by the Society in 1963 is in the sound interest of public health. It should not be delayed longer.

The Planning Committee feels that more progress can be made in the next sixteen months than in the last. These practitioners are treating the sick and doing so with an unlimited license. The medical profession should undertake more active programs in support of postgraduate courses to supplement their current knowledge in areas of scientific medicine, such as inviting their attendance at the scientific program during the course of the Society's annual meeting, as well as at the numerous teaching clinics held in the state.

Their subscription to the *Wisconsin Medical Journal* should be encouraged, and in other manner these practitioners who are considered to be ethical and capable should receive the benefits of training in scientific medicine just as do those having the degree of doctor of medicine.

The committee asks that the Council accept this report and forward it to the House of Delegates with the Council's favorable recommendation. Attached as exhibits are:

1. Statement of Policy adopted in 1963
2. Proposed release to news media
3. Proposed bulletin to presidents and secretaries of county medical societies.

The Council should note that this action (if approved by the House) constitutes a request by the State Society of county medical societies only, and that no osteopath has any right to demand that it be taken.

EXHIBIT 1

Statement of Policy on the Relationships between Doctors of Medicine and Doctors of Osteopathy . . . adopted by the Council of the State Medical Society of Wisconsin in February, with concurrence by the House of Delegates in May, 1963.

Voluntary professional relationships between a Doctor of Medicine and a Doctor of Osteopathy should not be deemed unethical if the county medical society determines that the Doctor of Osteopathy:

(1) Is currently licensed to practice medicine and surgery under the Medical Practice Act of the State of Wisconsin.

(2) Practices the healing art founded on the broad and all-inclusive principles of scientific medicine.

(3) Submits himself and any hospital with which associated, if proprietary, to the same voluntary surveillance common to those hospitals which adhere to the principles of the Joint Commission on Accreditation of Hospitals.

(4) Does not possess, in addition to his degree of Doctor of Osteopathy and Surgery, the degree of Doctor of Medicine obtained solely by the transfer of credits and not by resident enrollment in an approved medical school.
(5) Comports himself according to the Principles of Medical Ethics as those Principles have been and will be applied or interpreted from time to time.

The State Medical Society of Wisconsin, by and with the consent and advice of county medical societies, will encourage such Doctors of Osteopathy as meet these standards to attend appropriate programs of postgraduate education, and will meet with representatives of the Wisconsin Association of Osteopathic Physicians and Surgeons on matters of mutual interest from time to time.

EXHIBIT 2

Proposed release to news media

MEDICAL SOCIETIES ENCOURAGED TO PROVIDE OSTEOPATHS WITH POSTGRADUATE COURSES

Madison—County medical societies in Wisconsin today were encouraged to consider osteopaths holding an unlimited license to practice medicine and surgery as potentially eligible to enroll in postgraduate teaching programs offered by the State Medical Society.

The Council (board of directors) of the Society initiated the action by the Society's House of Delegates. It pointed out that nearly a year and a half ago action had been taken to the effect that it no longer is unethical for a physician holding a degree of doctor of medicine (M.D.) to engage in voluntary professional relationships with a doctor of osteopathy and surgery (D.O.) providing that the osteopath practices according to the all-inclusive principles of scientific medicine and the Principles of Medical Ethics of the American Medical Association. Such practitioners, said the Society, are not to be classified as cultists.

The House adopted the report and requested all county medical societies in Wisconsin to take appropriate action. It was pointed out during an hour-long hearing on the report that action by county medical societies was not mandatory, and no osteopath has any right to demand that it be taken.

EXHIBIT 3

Proposed bulletin to all presidents and secretaries of county medical societies

Dear Doctors:

REPORT ON DOCTORS OF OSTEOPATHY AND SURGERY

Enclosed is the report adopted by the House of Delegates relating to these practitioners and urging review of their ethical and scientific practices to determine eligibility to participate in various scientific programs of the Society.

Also enclosed is a list of such doctors, holding the unlimited license, currently practicing within the jurisdiction of your county society.

It is hoped that you will report back to this office as soon as any action has been taken as the list of those acceptable is to be compiled here and made available to those committees and commissions in charge of various teaching programs of the State Medical Society of Wisconsin.

It may be that you will wish *biographical data* as to those osteopaths in your area. We are endeavoring to compile relevant information and to make it available to you, should you wish.

C. H. Crownhart
Secretary

SUPPLEMENTARY REPORT OF THE COUNCIL (C)

Resolution 2, of May 1964, by the House of Delegates, requested a report in October of this year as to activities and costs of the Field Service division.

The Finance Committee reviewed the material and the Council approved transmittal of the report as prepared by Mr. Reynolds, Director of this service.

Report on Activities and Services of the Department of Regional Services January-October 1964

The Department of Regional Services consists of three employees. One lives and is based at Wausau, Wisconsin, Mr. Glenn C. Waldschmidt. He is assigned to cover 21 county medical societies in the northern and western part of the state. Mr. Lawrence W. Ryder lives in Menasha, Wisconsin, and services 21 county medical societies in the northeast and east-central areas. David C. Reynolds is based in Madison and in addition to directing the department makes service calls in the southern counties of the state.

Actual and projected costs of staffing and operating the department in 1964 will be $36,899.70. This is a reduction from the amount budgeted for 1964 of $3,300.30. Anticipated costs of operating the department in 1965 are $38,600.

Among services and activities of the department are the following:

- Attending county medical society meetings on a regular basis.
- Meeting and assisting county medical society officers.
- Meeting and assisting councilors and officers in areas serviced.
- Developing first-hand liaison between the county medical society and the activities, programs and services of the State Medical Society.
- Investigating and reporting grievances upon authorized referral.
- Assist hospital medical staffs.
- Contact each new physician in area serviced with the SMS-WPS story.
- Work with medical auxiliaries.
- Conduct programs regarding state and federal legislation.
- Maintain liaison between physicians and the several services and activities of the Society.
- Conduct SMS and WPS educational programs for medical assistants.
- Maintain active and close relationship with clinic managers and hospital administrators in the area serviced.
- Develop and maintain contacts with nonmedical activities such as local chambers of commerce, banks, clergy, pharmacists, other influential segments of local society.
- Attend many of the SMS committee and commission meetings to obtain first-hand decisions, recommendations, and matters of policy implementation.
- Provide services desired by county medical societies.
- Act as a catalyst in obtaining accurate answers with respect to physician questions.
- Provide speaking service to nonmedical groups.
- Sell the services and programs of the SMS to physicians in the area assigned.
- Establish a strong working relationship with the WPS division of the SMS at all levels and with all contacts.
- Measure local public opinion toward medicine.

Each of the activities listed above has been and is being carried out in the areas served by Glenn

GLENN WALDSCHMIDT

LAWRENCE RYDER

Waldschmidt and Lawrence Ryder. As time and budget permits, such regular services will be offered to the county societies in the southern area of Wisconsin.

One interesting statistic during the first eight months of 1964: Glenn Waldschmidt traveled 20,922 miles carrying out his assignments.

It is hoped a fourth man may be added to the staff of the department to provide the services described above and others to the physicians in southwest, central and eastern Wisconsin.

Respectfully submitted,
/s/ David C. Reynolds
Director, Regional Services

SUPPLEMENTARY REPORT OF THE COUNCIL (D)

The 125th Anniversary to be Commemorated in 1966

Past Presidents of the State Medical Society have been constituted as a special committee to develop plans for commemorating this occasion throughout the year of 1966. Its report (attached) is submitted for information of the House and reference to the Committee on Resolutions.

Facing the Future with Vision

It seems that there must be a clear understanding of why and how the Society should use the occasion of its 125th Anniversary Year, 1966, to engage in projects special to that year.

If the occasion is to be viewed only as one of "celebrating a birthday," then it can be done quite simply and with the minimum of financial commitments.

As more appropriately conceived, however, this occasion should be one during which the progress of medicine in the last twenty-five years can be related to the general public. (The first 100 years were recognized in 1941.) We should endeavor to engage the public's pride in sharing this record of progress and hope for the future. We should use the year to stress the interrelationship of the science of medicine to its practice, and the public should find in our activities renewed faith in the ability of medicine to do a job and to face the future with vision.

The strength of free enterprise in medicine should be related to its accomplishments. The concept of medicine as the leader, not the follower, can be stressed as a necessary element in its future service to the people.

Medicine must be emphasized as a service, not a commodity, and its availability to mankind regardless of race or economic status must receive prime attention.

Developments in the area of medical education, including that of groups ancillary to medicine, and the proper interest of the public must be demonstrated.

Public health services as teamwork should be related to the over-all programing, and leadership be asserted in the many ways available to the profession.

Wisconsin medicine, in the year 1966, can bundle up the past record and tell of its objectives for the future, spanning the next decade or more. A milestone is something which is passed, not a point at which to stop. Vision is the ability to project the intangible to the tangible. And without vision, it goes without saying, there would not be progress.

If this concept and total project is acceptable, then the matter would involve consideration of the following:

1. The Annual Meeting Program in La Crosse

The Commission on Scientific Medicine be encouraged to use the theme of "Facing the Future with Vision" in as many of the scientific papers and exhibits as possible.

Advance planning would be encouraged to obtain commitments from graduates of Wisconsin and Marquette medical schools located in other states to participate in the program. A special appropriation for honoraria and travel would be needed to supplement funds available from the Annual Meeting budget itself.

Those committees and commissions reporting to the House of Delegates would be asked to develop their long-range planning as well as to report current activities.

2. Regional Programs

There are many Wisconsin "greats" and appropriate programs are entirely feasible to recognize their contributions and how they pointed the way to the profession and public of their day. While associating part of the history with the year 1966, such occasions would principally take advantage of the opportunity of facing the future with vision.

These programs would perhaps be in the late afternoon for local physicians, with a subscription dinner and program in the evening for the general public.

These examples of such occasions are incorporated only to point out possibilities:

In Fond du Lac, recognizing the first president of the State Medical Society, Dr. Mason Darling, the first also of his profession to settle there. Others who might be honored in this program: Dr. S. E. Gavin, Fond du Lac, and Dr. Nicholas Senn, of Elmore, Fond du Lac County. The theme would be medical organizations of the future.

In Appleton, utilizing the theme of public health programs look to the future, honor also Dr. J. T. Reeve of that city, the first secretary of the State Board of Health, organized in 1876. Doctor Reeve served 18 years in that position, as well as carrying on an active medical practice. He was president of the State Medical Society in 1875.

In Ashland, recognize the physician who serves far beyond the call of his professional duties and the continuing need of such service in the future. Such a man was Dr. Edwin Ellis, 1824–1903, known as the "Father of Ashland." One writer has said of him that "the work of Doctor Ellis as a school teacher and physician was to become a vast contribution to education and public health."

In Milwaukee, among the many whose contributions to public health and welfare have been outstanding, there might be a rededication to the goals of Dr. Hoyt E. Dearholt, who, as director of the activities of the Wisconsin Anti-Tuberculosis Association, developed a winning program for education, prevention and treatment. Here the vision of the future might be to emphasize the continuing efforts to control and eradicate diseases prevalent in our times.

These four are incorporated only to suggest possibilities. Others might involve themes developed around the renowned deeds of Beaumont, Murphy,

Bardeen, Eben Carey, Sippy, Ochsner, Billings, Favill, Birge in the basic sciences, and numerous others.

3. Medical School Programs

This would appear to be an area of special consideration. In both *Milwaukee* and *Madison* appropriate programs could be developed relating not only the epochal period of the Flexner report and progress since then, but also plans of the future and future needs of our citizenry.

At the University of Wisconsin, the Conrad Elvehjem Memorial Lecture (underwritten by the CES Foundation) could be presented. On the topic of the basic sciences, the future might well be projected, its apparent complexities, and the needed interrelationship of the basic sciences and clinical teaching with faith one in the other. An out-of-state speaker could be brought to this occasion, which would be developed around a special appearance before the faculty and the student body, with a less technical program visualized for general public consumption in the evening.

A somewhat similar program could be developed at Marquette. Noting the substantial contributions of Doctor Jermain, first Dean, Dr. Walter Sullivan, and the Jesuit Order, this program could be based on the future of the privately organized school, its dependence upon philanthropy and general public support, and its potential needs.

The two programs would provide the contrast, in part, between the privately operated and the tax-supported institutions.

4. State Universities and Private Colleges

Recognizing that these institutions are now, in some instances, providing premedical education, degree courses in various areas of service ancillary to medicine, the theme of one program in Wisconsin could well be directed toward the future such institutions will play in serving health needs of our people. This might conceivably honor President Van Hise of the University of Wisconsin who crystallized the need of preclinical training at the University of Wisconsin, although achievement of the full course in medicine was not until 1927. Certainly the population explosion of current times and the vast growth in total population anticipated in the next three decades point to consideration of the integration of state universities and private colleges in phases of premedical and similar training. This well illustrates the theme of Facing the Future with Vision, and in this and other instances the leadership of the medical profession in doing so.

5. Women and Health

Laura J. Ross was Wisconsin's first woman doctor. In 1869, she called the first woman suffrage convention in Wisconsin. Using her example of constructive activity, we can visualize a special program based on the over-all subject of Women and Health. While nursing dates back some decades, it was not until 1912 that registration of nurses was required in Wisconsin. At the present time there are a score or more of occupations ancillary to medicine in which services are principally provided by women. How is the future to care not only for the increasing number needed, but for enrollment of students with necessary basic qualifications? These and a host of other questions would tend to stimulate thoughtful consideration of the general matter, and bring forth details of some of the future planning.

6. The Wisconsin Work Week of Health

First held in 1963, this week of intensive discussion of health affairs met with initial acclaim, and in 1964 drew even greater applause. In 1966, this occasion might well be based on the theme of the Society's Anniversary Year. Such topics as the following might be incorporated:

The Voluntary Agency of the Future and the part it should play in developing the health programs of our state.
The pros and cons of state autonomy in determining health programs as against direction by the federal government.
Similarly, the pros and cons of local autonomy as against control and direction by the state.
The future of drives to eliminate quackery.
Our state and county institutions and their future. What can be done, through various health programs and early detection, to avoid custodial care?
The news media—their obligation in furthering sound public health education.

These suggest topics which could be developed to be provocative of constructive thinking and of charting future activity and policies of the profession and allied groups.

The introduction to this report stressed the theme of Facing the Future with Vision.

The conclusion of this report adds to that theme the phrase "and with positive, aggressive leadership." The currents of postwar activities have increasingly put the profession of medicine on the defensive. Medicine, other than in its purely scientific achievements, and sometimes then (report on Krebiozen, for example), has been looked upon as regressive rather than progressive, against rather than for. Nothing is further from the truth, and it is time to say that we of medicine are

Facing the Future with Vision
and with positive, aggressive leadership!

ADDENDA

7. Other, but "unjelled" 1966 projects:

a. A special issue of the Wisconsin Medical Journal with cooperation of regular advertisers (comparing, possibly, advertisements of 1940 with those of today)—perhaps feature-type advertisements telling the story of pharmacy during the past 25 years and what is anticipated for the future.
b. Dedication of the Presidents' Room in the home of the State Medical Society.
c. Special issue, La Crosse newspaper.
d. Program of feature stories during the year and publicity attendant upon special programs. Develop, if possible, editorial comment.
e. Pictures.
f. Health Achievement publication to document record of the last 25 years.
g. Joint programs with allied agencies, such as the Wisconsin State Dental Society, Wisconsin Hospital Association, Wisconsin Pharmaceutical Association, Wisconsin Veterinary Medical Association, etc.
h. Feature Wisconsin's contribution to the voluntary health insurance movement.
i. Space medicine, environmental health, industrial health, occupational health, traffic safety, athletic injuries, and the use of chemicals and insecticides.
j. Solicitation of congratulatory messages from medical, civic and other leaders and organizations, to be incorporated in a bound book for historical record.
k. Integration of March of Medicine programs at least in part.
l. Participation of AMA in a portion of program.

8. Some devices intended to commemorate the year and implement the activities:

a. An expression common to the printing and advertising trades is "logo," an abbreviation of logogram, meaning a symbol or other kind of abbreviation to signify a special occasion or circumstance.

A logo is conceived for 1966 to be used:

On all stationery and other printing in connection with 1966 official SMS events.

On mementos, possibly in the form of small glass trays, for such events as dinners and area activities.

In full dimension, as medallions to be presented guest speakers and other notables to recognize in lasting fashion their participation in our 1966 activities.

Possibly on backdrops for use on the podium at lecture events.

b. An Executive Committee of Past Presidents is needed to:

Approve the special events to be held in the state as valid and appropriate.

Act in coordination of the total program and to serve in liaison with other Society committees.

Establish liaison and cooperation with county medical societies in areas in which special programs are envisioned.

c. A committee of the Auxiliary is needed for the duration.

d. Special planning is indicated to provide a limited number of exhibits to "liven" up the occasions of note. The most obvious is perhaps to use the Bohrod paintings for such events.

e. Appropriate exhibit planning for La Crosse and in the home of the State Medical Society.

SUPPLEMENTARY REPORT OF THE COUNCIL (E)

A Proposed Budget for 1965

By action of this House, the Council was requested to prepare a proposed budget for 1965, to enable the House to determine dues for that year.

This budget has been specially studied, informational material has been prepared, and it is transmitted in compliance with the resolution.

The Council joined in the recommendation of the Finance Committee that the regular membership dues be increased $10, and that an additional $5 be added to the dues for allocation to the Charitable, Educational and Scientific Foundation.

Introduction to
1965 Proposed Budget
State Medical Society of Wisconsin
October 1964

The gross budget of the State Medical Society, *in round figures*, approximates ---------- $100,000

Revenues for this budget are derived 75% from dues, from income earned through advertising in the *Wisconsin Medical Journal* and annual meeting exhibits, which together total about $65,000, with the balance coming from miscellaneous sources.

In the administration of a professional organization it is a rule of thumb that salaries and related payroll expense, such as Social Security and Unemployment Compensation, should be about 50% of the income derived from the dues structure itself, and such is the case in the affairs of the State Medical Society where the total payroll is $165,000—$10,000 of which is charged to the Journal, making a net payroll of $155,000 or slightly more than 50% of the income anticipated from dues.

In presenting budgetary needs for 1965, payroll has been excluded from project costs, as payroll serves across the board and in a variety of ways, and it would be burdensome as well as unnecessary to time record every project. However, in the ensuing report where there is a substantial impact on time, it is inferred but not evaluated.

The cost of committee meetings, meetings of the House of Delegates, the quarterly or more meetings of the Council acting as the board of trustees, the delegation from Wisconsin to the American Medical Association, individual expenses of committee members when billed, providing speakers, etc., in round figures totals --- $ 30,000

There are many routine activities of the organization which must be carried on and constitute the nub of our organization. These include membership services—billing and collection of dues, remittance of dues to the American Medical Association, information to new members, membership inquiries, placement services, membership certificates, and changes of address.

In addition, there are benefits available to members of the Society including a group disability program, Blue Shield insurance, group life on a health questionnaire basis, participation in the Open Panel program provided Wisconsin industry every three years.

The total cost of membership services annually, including the Open Panels, is ---------- $ 20,000

Another area of service is one of communications to the public in areas of public health education. This includes the preparation of a weekly radio script by Doctor Tenney known as the March of Medicine and carried on 51 stations each week. The tape recording is prepared at WHA and involves circulation of tapes to these stations with appropriate introductory script, the handling of much correspondence which is the result of these weekly broadcasts, including the availability of the script itself on request. It is estimated that the cost of this service annually, including Doctor Tenney's honorarium, is approximately ---------- $ 10,000

Another area of public service involves the work of the Commission on State Departments which has ten divisions, such as those on Maternal and Child Welfare, Aging, Rehabilitation, Public Assistance, Safe Transportation, and others. The Commission meets quarterly and the divisions meet as needed. The Commission coordinates the work of the divisions, each of which is advising one or more state departments in these various areas of public health concern. To illustrate but one, Safe Transportation is concerned with driver licensing laws, licensing of the epileptic, the medical profession's responsibility in such matters as proper cautioning of the driver who is under medication, liaison with the Wisconsin Council of Safety, and many other matters in this complex subject.

Staffing of the Commission and its divisions involves the part time of three administrative employees along with clerical and other assistance. The product is advice rather than the issuance of documents and publications.* But the advice finds its way not only to the agencies involved but to the public by way of lectures, helpful hints in radio announcements, and similar material. If a dollar sign were to be placed on this activity, it might be estimated at about ---- $ 8,000

Other activities in public information are under the guidance of the Commission on Public Relations and Communications which develops such material as that intended to interest students in health careers, the release of periodic public health information to news media, the development of such publications as the press-radio-TV code, occupational health guides including those for employees of hospitals recently approved by the Council and House of Delegates, and similar activities. This Commission is planning reentry into the area of occupational health programs in which nurses, personnel administra-

* These guides, however, have been developed in recent years:

School Vision Screening Program
Athletic Competition for Children
Recommended Immunization Procedures
Principles for Transporting the Ill and Injured

tors and others in industry, the insurance industry, the medical profession, the nursing profession and others are brought into periodic and regional conference.

The cost of this activity varies from year to year, and at this point it might be worth while to mention that the calendar year does not mark the boundaries of many activities of the profession, as they may be planned in one and executed in another; but on an average annual basis the cost of this general activity may be estimated at ---------- $ 5,000

The *Wisconsin Medical Journal* is a substantial project of the Society. It is the official publication and in that capacity carries many notices, minutes of meetings of the House of Delegates and of the Council, and similar items. It is the medium in which the authors of this area may convey their observations in scientific fields to their fellow practitioners. It carries material of interest to all members in many matters of medical economics, or, as in the current issue, the responsibility of physicians in aiding their patients to secure appropriate benefits under various public laws, including accelerated benefits of the Social Security Act.

A full-time assistant managing editor and one full-time assistant are employed, with others of the staff contributing in over-all direction of the Journal. Its publication costs in 1965 are estimated to be about $45,000, and while advertising revenue will offset the largest portion of this cost, nevertheless the dues structure will be called upon to provide financial subsidy ------- $ 10,000

A substantial area of activity involves appropriate information to state and national legislative bodies and to the membership concerning public health legislation. While this frequently is thought of as a narrowly confined field involving controversial areas such as chiropractic, limited licentiates in the health field, and areas involving the beneficence of government in the provision of health care, the responsibility of the profession is actually much broader.

The profession is concerned with legislation adequately implementing public health bodies such as the State Board of Medical Examiners, the State Board of Basic Science Examiners, and the entire area of public health. Questions involve such subjects as enabling legislation for county or multiple-county health departments; vital statistics requirements; the facilities of various state organizations; and proper implementation through adequate mental health legislation on the subject of the "dangerous offender" —the individual whose immediate offense may apparently be of minimal consideration, but where all indications are that it will become repetitious and increasingly dangerous.

The Society participates in discussions on proposed legislation and regulations such as those involving nursing homes or proposals that an application for a driver's license contain a consent for a subsequent test for drunken driving should the driver be accused of such conduct. It concerns itself with the broad matter of nervous and mental diseases and the comprehensive planning now being undertaken by public and voluntary agencies. These only illustrate the broad spectrum of activities which command the attention of many of the committees and subcommittees of the Society.

These and many other items might be broadly grouped under the field of legislation which is justifiable as much of the initial impetus comes from appropriate enabling legislation. Much of the activity is between sessions of the Legislature and in no manner is to be construed under the classification of lobbying. These costs are estimated to total in the neighborhood, annually, of ---------- $ 25,000

There is an area of activity which is not readily categorized but in a broad descriptive sense would be called the relationship of the physician to his public as well as to the public broadly. With the expansion of hospital services and the growth of hospital facilities, a broad program of hospital relations has been a subject of activity for the last 10 years. This relates to working with the hospital professional staff in its relationship to hospital administration; the relationship of hospital activities with those of the medical profession; complaints and inquiries of the public on similar matters.

At one time the Society endeavored to place this activity in (1) the category of hospital relations, and in (2) the category of "grievances." However, it was found that "grievances" was a narrow term and that "misunderstanding" more appropriately described the activity; and furthermore, that the physician in the hospital and the physician in the public were not separable in themselves.

The executive staff of the Society meets periodically with executives representing other health organizations; the executive committees of the Wisconsin Hospital Association and of the Council of the State Medical Society are meeting periodically; field men are on the road to interview, explain, and provide services; special articles are prepared from time to time in the Wisconsin Medical Journal, and service brochures are issued relating to the interpretation of the law relating to the salaried and nonsalaried physician, the inspection of hospital records, the fee splitting statute, compulsory reporting situations, and comparable subjects. To continue these important activities involves an expenditure of probably -- $ 20,000

During the past two years the Society has engaged in concerted efforts to provide information to the public in areas obviously demanded by current developments of one sort or another. Prior to that time many individual releases, half-day institutes, one hour programs incorporated in some other program, and other devices had been used to convey the profession's concern in and objectives with its responsibility to various segments of the public.

Through concentrating these activities in such programs as the *Wisconsin Work Week of Health*, literally thousands of contacts have been made as to all of them rather than a limited number as to some of them. The program format for the Work Week of Health is so devised as to give a great deal of information concerning Society pronouncements and activities in any number of matters, and there is no need to do other than refresh the memory of the House concerning those programs. Some 10 to 15 thousand are mailed to civic leaders throughout the state and to organizations especially interested in health per se. All told, these combined and concerted efforts of public health education involve an annual expenditure of approximately ---------- $ 35,000

While annual meeting expenses are pretty much met out of exhibit income, this does not include the time of Mr. Ragatz, which is very substantial, or secretarial help and some other related costs including that of staff on duty at the time of the annual meeting itself.

Not calculated in the budget are duties imposed on the staff by reason of activities carried on through mechanisms of the CES Foundation, handling of the museum project, the student loan account, and similar matters. The CES Foundation does more than offer a promise of future activity. It points a steady finger in its direction, for through the concerted efforts of this device, much more may be anticipated by way of medical student education. As to activities of the medical profession, the provision of scientific teaching programs for county and district meetings, the coordination of field programs in specialized areas as may be necessary from time to time, meeting the profession's responsibility in such public health problems as posed by Menominee County.

It would be possible for the Society to develop subjective budgetary reports in which each project or activity is detailed and costs substantiated as to such items as supplies, postage, travel, salaries, etc. However, it has been felt that an overall review on an estimated basis would serve as an introduction to the objective reporting which relates the costs of the Society to a general accounting system under the broad titles of legal services, postage, printing and forms, rent, telephone and telegraph, etc., which is the customary and traditional way of preparing budgetary costs of operation.

In most respects the annual budget reflects approval or action by the House of Delegates in directing the institution or development of certain programs. For example, Resolution 4 (May 1964) of the Management Study Committee urged the Society to maintain strong relationships with other professional groups; stimulate new public education programs; and continue to study social problems. Such a resolution implies across-the-board activity, as "new public education programs" can hardly be merely a continuation of those in the past.

The direction of Resolution 1 that programs and services of the Society be developed continuously to meet varying needs throughout the state requires various committees to reanalyze their functions in light of current trends, and develop and report back to the Council or the House recommendations which they think will meet such a direction of the House.

These studies of programs and services involve a very considerable amount of staff time and committee deliberation, as well as costs of execution of recommendations.

At the May 1964 meeting, two one-day symposiums on Town-Gown problems in Madison and Milwaukee were approved, as well as continuation of the Wisconsin Work Week of Health and public education on Health Fads and Fallacies in 1965. These programs are reflected in the recommended budget, Account 600.

The 1966 Annual Meeting, by action of the House of Delegates, is to be held in La Crosse. This significant year in the history of the Society —marking its 125th Anniversary—is one requiring planning beginning in 1964, and the Past Presidents of the Society have been constituted a committee for this purpose. In contemplation of its deliberations, as well as other considerations, special budgetary provision is indicated, at least $10,000, of which $5,000 will be necessitated in 1965.

The Council in 1963 announced its intent to call fall meetings of the House of Delegates, but implicit in that statement was that there be sufficient business for it to consider. The House in May of 1964 amended the Bylaws to make a fall meeting mandatory. Direct expense of a fall meeting of the House is about $2,500, but the indirect expense is consequential. This means another report by the Speaker and Secretary to all delegates and alternates "as soon as possible" after the House adjourns. Other expense involves circulating the call and reports to a mailing list of approximately 450, additional copies of committee reports, notifying county societies of deadlines for filing resolutions, and a further set of minutes printed in the Wisconsin Medical Journal. Staff time is measurably involved in preparation for and attendance upon the second session of the House. The Secretary estimates that all told the cost of the interim session could well run in excess of $6,000.

Special note regarding the Wisconsin Medical Journal: Due to a substantial decrease in advertising, a problem encountered apparently by all medical journals, 1965 costs of the Journal are estimated to be in the neighborhood of $10,000 in excess of advertising revenue. The Society for a number of years has allocated $3,000 to subsidize the Journal for costs of preparation of special articles of one sort or another, the Blue Book edition, etc. It appears, however, that this appropriation will have to be increased by $7,000 for 1965. Various efforts are being made to secure additional advertising through contacts made locally, but the limited circulation of the Journal does not make it a strong advertising medium.

Finally, responsibilities in the legislative halls are numerous. Of the approximately 1800 measures introduced in the Wisconsin Legislature, one can estimate 10 per cent to involve public health directly or indirectly. National legislation is more complex but of equal importance, and while the AMA has provided much assistance, still each state society is expected to participate actively in these programs.

No professional association worthy of public trust can fail to measure to its professional responsibility in apprising legislators and others of the nature of this legislation. Neither can a professional association construe its task as a narrow one. Much legislation affects the science of medicine rather than economic aspects, and the duty of the profession of medicine is obvious.

Anticipated SMS Income, 1965

Dues, all membership classifications	$305,000
This assumes dues remaining at the amount of 1964 and is a conservative estimate because of the fact that we cannot predict how many additional physicians will come into Wisconsin during the year. In 1964 we estimated dues would produce $305,000, but actually the income was about $4,500 more.	
Wisconsin Medical Journal, advertising	35,000
Annual Meeting	28,000
Dues, Section on Medical History	1,500
These funds are not available for general Society purposes, but rather to implement activities of the Section on Medical History, aid in the acquisition of memorabilia and in the development of exhibits.	
Reimbursement from Dane County Medical Society	2,700
The costs of doing a certain amount of clerical work in maintaining records of the Dane County Medical Society were reviewed by our internal auditor in 1964 and arrangements were worked out for Dane County to increase its remittance by $900.	
Reimbursement for work performed, and supplies used, for other divisions including Field Service	11,000
Certain work performed as a Society service is actually in behalf of the Realty Corporation, WPS, and other activities. These services are charged out periodically and while treated as income, this actually is a not-for-profit operation. This amount includes $10,000 anticipated as a charge to WPS for certain work conducted in the field service which is more fully explained in a special report.	
Miscellaneous (reprints, bound copies of Open Panel, etc.)	1,500
	$387,700

SMS Proposed Budget, 1965

Acct. No.		*Normal*	*Special*
506	*Dues*	$ 1,450	
	The Society is a member of such organizations as the Better Business Bureau of Milwaukee, Wisconsin Council of Safety, Professional Convention Management Association, and the American Public Health Association. It supports with five other states the cost of the North Central Conference and participates in the Conference of Presidents and Other Officers of State Medical Society. It also supports the National Society for Medical Research (animal experimentation) and is a member of the Wisconsin Public Health Council.		
520	*Conference Expense*	$ 25,750	
	Council and committee meetings including travel expenses billed by physicians and consultants		
	AMA delegates and alternates' expenses for meetings in New York and Philadelphia		
	President's travel allowance, in- and out-of-state		
	Annual Meeting expenses of Society officers, committee members, facilities for House of Delegates, luncheons and dinners (largely recovered in income)		

Acct. No.		Normal	Special
	Special meetings to discuss interprofessional and other problems; expenses of attending national conferences		
	*Interim House of Delegates meeting		
	*Costs of the interim session, without any allocation of staff time in special travel, but allowing for luncheons, preparation and mailing of the handbook, including postage, Master Reporting and other services, amounted in 1963 to approximately $2,500. The impact of special circulation of material relating to the management report was charged to its budget rather than to this account, or account 565.		
522	*Promotion*	$ 6,100	
	Costs of educational exhibits; photographs for news releases and other promotion; pamphlets for special distribution; public information services such as First Aid Charts; general Society promotion		
	Promotion cost for annual meeting such as printing of programs and announcements in WMJ (recoverable in income)		
525	*Depreciation*	$ 3,000	
	Computed at current rates on existing equipment and projected for equipment purchases in 1965		
535	*Grants and Appropriations*	$ 3,700	
	Support of State 4-H activities		
	CES Foundation to support teaching programs		
	Governor's Committee on Employment of Handicapped		
	Student AMA Chapters		
	*Aid to needy physicians		
	*The Society, from the dues structure, maintains a fund of $1,000 in the CES Foundation from which grants are made on recommendation of councilors and officers of county medical societies when a physician is in need. This appropriation is not always needed, but at least some portion of it is required each year.		
541	*Insurance—General*	$ 2,500	
	Annual cost of basic insurance including bonding of employees and officers, fire and liability		
	Travel accident policy		
550	*Miscellaneous Expense*	$ 3,000	
	An amount normally provided for items not related to other account classifications		
	Annual meeting miscellaneous items (recoverable in income)		
	WMJ miscellaneous (partly recoverable)		
556	*Office Supplies and Expense*	$ 3,000	
	Normal requirements for mimeograph stencils, IBM forms, Xerox, carbon paper, ribbons, files, vouchers, card stock and other items		
	March of Medicine tapes and mailing cases		
	Annual meeting badges		
557	*Outside Services*	$ 7,400	
	Clipping Services		
	March of Medicine recording		
	March of Medicine emcee, Doctor Tenney		
	Annual meeting expenses (recoverable)		
	Manpower		
	Miscellaneous charges		
562	*Postage*	$ 11,400	
	Routine requirements		
	March of Medicine, distribution of tapes		
	Annual meeting (recoverable)		
565	*Printing and Forms*	$ 44,950	
	Wisconsin Medical Journal (estimated publication cost)		
	Annual meeting items such as delegates handbook, registration cards (recoverable in income)		
	Interim meeting handbook, etc.		
	Badger Doctor's Wife and other Auxiliary printing		
	Membership certificates		
	Special legislative bulletins		
	Routine printing and forms—stationery, envelopes		
569	*Rent—Office*	$ 37,500	
	Space allocated to SMS and WMJ activities		
570	*Rent—Other*	$ 6,500	
	Auditorium rental for annual meeting including services of furnishing, installing and removing signs and equipment for exhibits (recoverable in income)		
572	*Rental—Equipment*	$ 1,500	
	Equipment rented for use at annual meeting (recoverable in income)		
	Xerox copy machine		
573	*Repairs and Maintenance of Equipment*	$ 1,000	
	Service agreements for addressograph, typewriters, dictating machines, and repairs to equipment		
577	*Resource Material*	$ 975	
	Legislative Service		
	Normal subscriptions and special publications		
579	*Speakers' Expense*	$ 3,500	
	Annual meeting speakers' honoraria, hotel and travel expense		
586	*Property Tax—Personal Property*	$ 350	
	Personal property tax on office equipment		
590	*Telephone*	$ 3,400	
	Normal toll charges, telephone and telegraph		
504	*Accounting Services*	$ 6,000	
	Services of independent CPA's to SMS and WMJ		
545	*Legal Services*	$ 5,700	
	Legal services to the SMS in areas of general administration, grievance investigations, membership problems, etc.		
	The above are routine services provided by legal counsel, but to an increasing degree special matters are presented during the course of the year which require action that cannot be anticipated at the time the budget is prepared. A contingency account of $5,000 is needed year in and year out.		$ 5,000
546	*Legislative Retainer*	$ 8,900	
600	*Special Budgetary Provisions*		$31,350
	Town-Gown Symposiums in Madison and Milwaukee		
	Wisconsin Work Week of Health		
	Conference on Health Fads & Fallacies		
	125th Anniversary Year		
	Special Public Information mailing list for Today's Health, AMA News and other special material		
	Memorials to CES Foundation for deceased members		
	Open Panels—1967 publication		
	Contingency Fund		
	Subtotal, Operating Budget	$187,575	$36,350

Acct. No.		Normal	Special
595	*Staff Travel Expense*	$ 10,000	
	Staff travel related to Society activities, including annual meeting, but excluding field service. Possibly $1,000 of total is recoverable in income.		
---	*Payroll*—except Field Service	$124,000	
	Current payroll plus an amount for adjustments during the year.		
---	*Related Payroll Expenses*	$ 18,000	
	Pension plan contributions, Social Security tax, unemployment compensation, and group insurance, estimated at 15% of payroll.		
700	*Field Service*	$ 38,600	
	Two full-time field men and director, payroll and related expenses		
	Travel, telephone and telegraph, and miscellaneous expenses		
	Total SMS Budget, 1965		
	Normal	$378,175	
	Special	36,350	
		$414,525	

SUPPLEMENTARY REPORT OF THE COUNCIL (F)

A resolution of the Milwaukee County delegation was presented to the Council last night, with the request that it be forwarded to the House. It reads:

WHEREAS, It has been called to the attention of various physicians that the present Wisconsin Statutes do not permit any physician to serve on the State Board of Medical Examiners who has any faculty tenure as an instructor, researcher, professor, or any connection with a medical school; now therefore be it

Resolved, That this House of Delegates recommends that *Chapter 147, Section 147.13, Paragraph 1*, of the Wisconsin Statutes be amended to read:

"Examiners. (1) The Wisconsin state board of medical examiners shall consist of 8 members appointed by the governor, 7 of whom shall be licensed resident doctors of medicine and one of whom shall be a licensed resident doctor of osteopathy. The 7 doctors of medicine, may, but need not, be selected from nominees of the Wisconsin state medical society and the doctor of osteopathy from nominees of the Wisconsin osteopathic association. The appointment of each member shall be for 4 years. Each member of the board shall be paid . . . ."

The Council considered the matter and suggests that there should be opportunity to study the implications of the proposal and therefore suggests to the House that this matter be referred to the Commission on Public Policy, with the instruction that it report back to the Council.

■ REPORT OF COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION —OCTOBER 1964

George B. Murphy, Jr., M.D., La Crosse, Chairman
T. H. McDonell, M.D., Waukesha
M. V. Overman, M.D., Neillsville
A. J. Richtsmeier, M.D., Madison
P. C. Dietz, M. D., La Crosse
H. G. Bayley, M.D., Beaver Dam
S. L. Henke, M.D., Eau Claire
R. P. Fruehauf, M.D., Superior
G. W. Hilliard, M.D., Milwaukee
E. A. Bachhuber, M.D., Milwaukee, Ex Officio
E. C. Albright, M.D., Madison, Ex Officio

Since the Commission's report to the House of Delegates in May, it has met twice.

One of the items under discussion by the Commission has been the subject referred to it by the House of Delegates—Resolution Number 24 introduced by the Manitowoc County Medical Society. It reads as follows:

"*Resolved*, That the State Medical Society of Wisconsin require the bylaws of the hospital staffs of all hospitals located in the State of Wisconsin, upon the staff of which are members of the State Medical Society, contained a provision in the bylaws of the staff of each hospital providing that before an appointment to the staff of said hospital is denied, revoked, withdrawn, suspended, canceled or not renewed, that said physician or surgeon be given the right of hearing prior to said action, and to be represented by counsel or any other representative of his own choosing thereat; that said physician or surgeon be given reasonable written notice of the time of said hearing."

The Commission previously has discussed the subject with representatives of the Manitowoc County Medical Society; but it apparently was not satisfactorily concluded by that organization. The Commission therefore considered it and it was its decision to communicate by letter with the Manitowoc County Medical Society, informing it that the Commission has again considered the resolution and invites its attention to the Wisconsin Supreme Court decision in the case of State ex rel Wolfe vs. La Crosse Lutheran Hospital Association.

That decision is to the effect that a private hospital has the right to exclude licensed physicians from the use of the hospital and that such exclusion rests within the sound discretion of the managing authorities. Thus, the action called for by Resolution 24 that the State Medical Society "require" the hospital staff bylaws contain a provision granting the right to hearing prior to denial of appointment, or suspension, or the like, becomes of no practical effect since no outside organization has the authority to require that such bylaws contain certain specific provisions.

The Commission suggests consideration be given to changing the word "require" to "recommend" and if this change is made the Commission will recommend the adoption of Resolution 24.

With respect to medical staff organization, the Commission urges medical staffs of Wisconsin hospitals to comply as best they can with the principles enunciated by the Joint Commission on Accreditation of Hospitals.

The Commission has considered the possibility of splitting into two subcommittees, one on hospital relations and the other on medical education, but has rejected this proposal. The Commission does not feel there is any practical need to split into two groups nor to appoint special subcommittees in these two areas. The Commission believes that knowledge and familiarity of medical education with hospital relations and vice versa is of benefit to itself and to its members.

The Commission enthusiastically welcomes the opportunity of organizing the Symposia approved by the House of Delegates through Resolution 22 last May. The target date for programs in Madison and Milwaukee is late March 1965. The format of the Conferences and preparation of the program is currently in the planning stage of the Commission.

The Commission is following closely State Board of Nursing recently issued proposed new regulations on the unauthorized practice of nursing. Such regulations provide for the establishment of a new category of nursing personnel known as the "nursing assistant" without provision for such recognition in the statutes. The proposed rules would make each employer of nurses responsible for having written

evidence of a current Wisconsin certificate or permit number for each registered nurse and a license number for each licensed practical nurse. It is the belief of the Commission this raises some question of the authority of the Board to regulate nursing through employers.

The Commission was concerned that a representative of the State Medical Society was not asked to participate in the drafting of the proposed State Board of Nursing regulations, particularly in view of the fact that each voluntary group represented on the State Board of Nursing was asked to participate except the medical profession. In view of the concern over the proposed rules, the Commission has asked that legal counsel prepare a statement on the revised proposed rules when they are made public, for presentation at subsequent hearing by a member of the Commission.

The Commission is in the process of reviewing the University of Wisconsin Medical School expansion program and intends to keep cognizant of all developments.

The Commission currently is planning a program on emergency care in the general hospital to be part of the Wisconsin Work Week of Health to be presented during the week of Feb. 22, 1965.

The Commission currently has under study a proposed model contract for in-hospital specialists which has been annotated by legal counsel.

■ RESOLUTIONS—OCTOBER 1964

RESOLUTION NO. 1

Introduced by: Survey Study Committee, October 1964

WHEREAS, The House of Delegates is the governing body of the State Medical Society of Wisconsin, incorporated under Act 53 of the Territorial Laws of 1841 which chartered this Society and gave legislative sanction to the Constitution and Bylaws as originally created, and as such is the only body with the authority to amend this Constitution and these Bylaws, and, furthermore, possesses certain fundamental inherent rights that are not altered by the subsequent general law covering nonstock corporations; and

WHEREAS, The Council of the State Medical Society of Wisconsin, under Article VI shall be the Board of Trustees of this Society and shall have full authority and power of the House of Delegates between sessions; now, therefore be it

Resolved, That Article VI be interpreted as granting the Council the authority to determine its own committee structure and the membership of these committees to best serve the interests of the Society and to engage the secretary-general manager and his principal assistants through contracts of employment; be it further

Resolved, That Article VI be interpreted as granting the Council the authority to enforce the Constitution and Bylaws and to adopt necessary regulations in management but not to change or alter the Constitution or Bylaws; and be it further

Resolved, That in Chapter VI, Section 1 of the Bylaws stating that the chairman of the Council shall make an annual report to the House of Delegates, be interpreted as implied, that this report shall include all major actions and policy decisions and that this report shall be subject to approval by the House of Delegates; and be it further

Resolved, That this resolution and all other resolutions pertinent to or explanatory of any portion of the Constitution and Bylaws be, hereinafter, designated as an annotation to the sections to which they apply.

Chapter III, Section 5(6), page 60
Chapter III, Section 5(9.2) page 65
Section 6(3.4) page 75

RESOLUTION NO. 2

Introduced by: Survey Study Committee, October 1964

Resolved, That the chief executive officer of the State Medical Society shall be the secretary-general manager. He shall be engaged by the Council as provided by the Constitution and Bylaws and shall be responsible for the operation of the State Society Office. He shall be charged with the execution of policy without assuming policy-making power and shall assist the officers in making decisions and taking actions, share his convictions and argue their merits as requested and acquaint the Officers, Council and House of Delegates with the need of change. Be it further

Resolved, That the secretary-general manager in collaboration with the Council make every effort to develop the positions of assistant secretaries for scientific medicine and insurance director, as full time positions with adequate salary and appropriate authority in the structure of the State Society Office. Be it further

Resolved, That the question of the status of the chief executive officer as a member or officer of the Society be considered by the Council in the future when selecting a successor to the secretary-general manager.

Chapter III, Section 6(3.4) page 75
Chapter V page 99

RESOLUTION NO. 3

Introduced by: Survey Study Committee, October 1964

Resolved, That the House of Delegates recommend to the Council that it annually review the services of general counsel, legislative representative, auditor, actuary, investment and other consultants with consideration of the extent of their utilization, the efficiency of their services, and the propriety of their charges.

Chapter V, page 99
Chapter VI, Sec. 4(6) page 156

RESOLUTION NO. 4

Introduced by: Survey Study Committee, October 1964

Resolved, That the House of Delegates recommend to the County Medical Societies that they make changes in their Constitutions and Bylaws that would limit the number of successive terms permitted in offices, limit their terms to three years, increase the size of their board of directors, and have wide representation on their nominating committees so as to best serve the needs of their societies.

Chapter VII, Part Three
Pages 160–177

RESOLUTION NO. 5

Introduced by: Survey Study Committee, October 1964

WHEREAS, The present method of districting is not equitable and deserves further study; and

WHEREAS, Redistricting is a tremendous problem in itself and one which requires undivided attention and consideration by a group not involved with other problems; now therefore be it

Resolved, That a special Ad Hoc Committee be appointed consisting of 10 members, one from each Congressional district. This Committee shall have the task of studying the subject of redistricting as it pertains to the House of Delegates and to the Council, and shall report its progress to each session of the House of Delegates until final conclusions are reached. It may consult with the Council upon request from itself or from the Council between sessions of the House of Delegates; and be it further

Resolved, That this Committee shall be appointed by a *committee* composed of the Chairman of the Council, the Speaker and Vice Speaker of the House of Delegates, and the incoming President.

Chapter III, Section 4(4) page 46
Chapter III, Section 5(5) page 58

RESOLUTION NO. 6

(Former Resolution No. 15 of May 1964)

Introduced by: Survey Study Committee, October 1964

Resolved, That the House of Delegates reaffirms the present method of selecting standing committees of the Society, and that, whenever possible, the Chairman of the Council, with the approval of the Council, shall appoint members with the objective of obtaining the fullest membership participation in Society activities.

Chapter III, Section 5(3) page 56

RESOLUTION NO. 7

Introduced by: Survey Study Committee, October 1964

WHEREAS, The Charitable, Educational and Scientific Foundation, in addition to the Museum of Medical Progress, is providing substantial sums to medical students at low interest rates, and is responsible for the greater portion of postgraduate medical education in the form of honoraria and expenses to speakers, and is giving financial aid to indigent physicians and their families, and

WHEREAS, From the Annual Report, the overall analysis of cost and functions appears to be favorable, and

WHEREAS, It appears that there is a great lack of understanding by physicians concerning all the functions as well as the needs of the Charitable, Educational and Scientific Foundation; now therefore be it

Resolved, That the Charitable, Educational and Scientific Foundation continue to operate for the best interests of the public through its programs of aid to medical students, postgraduate education and aid to physicians in distress and that it improve its reporting to the physician membership so that its functions are better understood; and be it further

Resolved, That thought be given to providing a full time manager for the Foundation whenever financially feasible; and be it finally

Resolved, That a voluntary annual assessment of $5.00 per member be added to the dues structure.

Chapter IV, Page 78–90
Chapter IV, Section 1(6.1) page 235
1(6.2) page 236
1(6.3) page 236

RESOLUTION NO. 8

Introduced by: Survey Study Committee, October 1964

WHEREAS, The Realty Corporation is well conceived and provides a means by which the Medical Society can conduct its financial activities, and

WHEREAS, Careful review of the financial structure of the Realty Corporation has shown it to be carefully and conscientiously managed, and

WHEREAS, Qualified consultation has been sought with disinterested experts on rental allocations, the mortgage payments and related items; now therefore be it

Resolved, That the Realty Corporation continue to operate in the best manner possible for the good of the Society, and be it further

Resolved, That the President present necessary details to the membership through articles in the State Medical Journal.

Page 91, 92, 95
Page 237 2(5)

RESOLUTION NO. 9

Introduced by: Survey Study Committee, October 1964

WHEREAS, Detailed study of the Booz, Allen and Hamilton Report revealed certain criticism of the Secretary and Staff of the State Medical Society that has been proven to be due to lack of complete understanding; and

WHEREAS, The reasons for other elements of criticism have been overcome; and

WHEREAS, The Survey Committee has received willing cooperation in the entire study; therefore be it

Resolved, That the House of Delegates express its confidence in the sincerity, integrity and ability of the Secretary and Staff of the State Medical Society.

RESOLUTION NO. 10

Introduced by: Survey Study Committee, October 1964

WHEREAS, The Program and Management Survey provided by Booz, Allen and Hamilton has served as a useful stimulant in the revision of our procedures and the improvement of our operations; now therefore be it

Resolved, That the report of Booz, Allen and Hamilton be placed on file for reference and the Survey Study Committee be discharged.

RESOLUTION NO. 11

Introduced by: Dodge County Medical Society, October 1964

WHEREAS, The Continental Casualty Company has, in its management of HAPA, seen fit to refer to the physicians of the State of Wisconsin as "vendors"; and

WHEREAS, The dictionary definition of a vendor is "one who sells," a description which is degrading to a profession; now therefore be it

Resolved, That the Continental Casualty Company, the State Department of Public Welfare and whatever other agencies or groups involved be firmly instructed to restore the physicians to their professional title and status no matter whether the term or number attached to it is more convenient from a clerical standpoint.

RESOLUTION NO. 12

Introduced by: Dane County Medical Society, October 1964

Resolved, That the Dane County Medical Society support and ask the State Medical Society of Wisconsin to join in support of efforts to obtain a Dean of the University of Wisconsin Medical School who is a physician, and is clinically oriented; a pro-clinical Dean would be more effective in turning out clinically oriented physicians for the State of Wisconsin; also, a pro-clinical orientation for the Medical School should be supported although research should not be stinted; and be it further

Resolved, That the President and/or the Council of the State Medical Society of Wisconsin make known to the President of the University of Wisconsin knowledge of our support of these views.

■ MENOMINEE COUNTY HEALTH SURVEY

A Profile of the Health Practices and Problems of the Indian Residents of Menominee County

This report was compiled by Martha R. Jenny, R.N. for the State Medical Society of Wisconsin through its Charitable, Educational and Scientific Foundation. The Western Printing Company Foundation of Racine, Wisconsin, supported the Survey with a grant of $3,000 which was also matched by the Foundation.

MENOMINEE COUNTY HEALTH SURVEY. Pictured at the August 1 meeting of the Committee are, left to right: Miss Martha R. Jenny, R.N., Madison; Dr. Glenn J. Stuesser, chairman, Madison; Dr. H. F. Laufenburg, Shawano; David C. Reynolds, State Medical Society staff representative, Madison; and Dr. G. M. Shinners, Green Bay. Doctor Shinners, District No. 6 Health Officer, although not a member of the committee, acted as advisor.

Members of the Menominee County Study Committee are: Glenn J. Stuesser, M.D., Chairman, Madison; Patricia F. Lanier, M.D., Kewaunee; E. P. Rohde, M.D., Galesville; E. R. Krueger, M.D., Hayward; George Nadeau, M.D., Green Bay; and H. F. Laufenburg, M.D., Shawano. George M. Shinners, M.D., Green Bay, Health Officer, District No. 6, acted as an advisor to the group.

Because of its length, the report will not be printed; however, copies are available on request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

TRANSACTIONS—PAGE 602

PHYSICIAN NEWS

Technologists Hear Physicians

Among the physicians who presented papers at the fall convention of the Wisconsin Association of Medical Technologists October 23–25 at Hilton Inn, Milwaukee, were Dr. Ennio C. Rossi and Dr. Edward J. Lennon of the Marquette University School of Medicine and *Dr. Philip E. Podruch* of the Milwaukee health department.

Nursing Homes Association

Dr. William J. Tucker, Ashland, was guest speaker October 20 when the Wisconsin Association of Nursing Homes, Districts 10, 11 and 12, met at the Marine Club in Ashland.

Dr. Cordes Participates in Conference

Dr. John E. Cordes, Milwaukee, participated in a conference on alcoholism for clergymen of all faiths November 4 at the Wisconsin Telephone Company auditorium in Milwaukee.

NEWS RELEASE issued October 2, 1964

Menominee County Health Survey Results Released

MADISON—Menominee County residents, though in need of improved sanitation, housing and better income, are neither as desperate nor impoverished as much of the publicity would suggest, according to a survey released today by the State Medical Society.

"They are not interested in more handouts in the way of 'goodies' or used clothing and even helpful services. What they want above everything else is a better income and better housing," the report states.

These impressions were registered in a 32-page report detailing the health status and conditions of Menominee County residents during a 6-month study conducted under the auspices of the Charitable, Educational and Scientific Foundation of the medical society.

The report will be considered by the House of Delegates of the medical society on October 10 and 11 during their annual interim session in Madison.

The 6-month health survey, designed to evaluate the total health conditions in the county and wherever possible provide education and health guidance, was conducted by Martha R. Jenny, a registered nurse with special training in public health nursing. A grant by the Foundation of the State Medical Society and the Western Printing Company Foundation of Racine made the survey, called "Operation Health Guard," possible.

During her 6 months in Menominee County, Miss Jenny contacted each of the 496 families in the area. She also conferred with community leaders, educators, county welfare officials, clergy, the public health nurse, physicians and hospital administrators. It is believed that this is the most exhaustive health survey ever conducted in the county.

Diabetes, heart disease and tuberculosis were rated as the three most common diseases, the report stated. An intensive case-finding and treatment program has exposed a greater number of tuberculosis cases to earlier treatment, improving chances for management or recovery.

Alcoholism, a high infant mortality rate and poor dental health were also frequently encountered health problems.

However, response to immunization programs conducted by the public health department is generally good and data gathered indicates adequate nutrition.

It was found that despite the closing of the hospital in Keshena, medical and hospital care was available from physicians and hospitals in the surrounding communities of Shawano, Green Bay, Antigo and Gresham.

continued on next page

MENOMINEE COUNTY HEALTH SURVEY

continued

The pressing problem among residents is the inability to pay for care. The median income in Menominee County is approximately one-half that of the state median, with one out of every six families having an income of less than $1,000 per year. There is a continued increase in unpaid bills in hospital and medical facilities adjoining the county.

Eleven recommendations were contained in the report. They were:

★ Institute a vigorous and comprehensive program for improving the sanitation in the county.

★ Secure funds for assisting families who are unable to pay their medical and hospital expenses. It was suggested that a loan or partial-pay basis would be preferable to welfare or subsidy.

★ Include in the immunization programs a plan for tetanus inoculations for mill workers.

★ Plan an intensive educational program in the field of maternal and child health.

★ Encourage comprehensive health guidance and teaching to all families having health problems.

★ Introduce a program to study and combat the problem of excessive drinking and alcoholism.

★ Consider setting up a program of education for planned parenthood and spaced pregnancies within the sanctions of individual religious beliefs.

★ Work with schools and other organized groups for future integration of their programs of health teaching.

★ Establish through philanthropic organizations scholarships for those interested in education and training beyond high school.

★ Explore the feasibility of setting up a regular public transportation system between the villages of Neopit and Keshena and the surrounding towns.

Dr. Randall Heads Drive

Dr. John H. Randall will head the 1965 Heart Fund campaign in Green Bay.

NINTH COUNCILOR DISTRICT

Two members of the Mayo Clinic staff at Rochester, Minn., presented papers at the meeting of the Ninth Councilor Medical District October 29 at Mead Inn, Wisconsin Rapids. Dr. Daniel Connolly's subject was "Cardiac Pacemakers and Related Problems." Dr. Emilio Giuliani spoke on "Direct Current Cardioversion" and the result of the first hundred cases.

The two doctors also participated in a panel discussion on "An Intensive Care Unit in a Community Hospital." On the panel, also, were *Drs. Gail H. Williams* and *F. W. Fletcher* of Marshfield, with *Dr. D. J. Freeman* of Wausau as moderator.

A new constitution was developed for the society replacing the one written in 1879 when the District was first formed as the Northwest Medical Society at a meeting in Amherst.

ACS Program in Chicago Features Surgery Shown on TV from Milwaukee

Physicians attending the annual clinical congress of the American College of Surgeons October 5–9 in Chicago had an opportunity to watch an unusual program. Via closed circuit color television, they could watch doctors from the staff of Marquette University School of Medicine in Milwaukee perform 14 operations at Milwaukee County General Hospital in Wauwatosa.

The television camera, which was developed by Smith Kline & French, the Philadelphia firm which sponsored the show, permitted the physicians gathered at Chicago's Pick-Congress Hotel to peek over the surgeon's shoulder via an 8 x 10 foot screen. On another screen, a panel of four top surgeons commented on the operation's progress.

MILWAUKEE JOURNAL Photo

DR. EDWIN H. ELLISON, second from left, performs gastric surgery. The mirror (upper), which is constructed of a special flawless glass, transmits both the view for the camera and light from the camera to the working area. Doctor Ellison, working skillfully, wears an earphone in which he can hear the commentary by the panel of doctors, and a microphone (not visible), which permitted two-way conversation.

TRANSACTIONS OF HOUSE OF DELEGATES

INTERIM SESSION • OCTOBER 10, 1964 • MADISON

SATURDAY MORNING SESSION

October 10, 1964

The Interim Session of the House of Delegates of the State Medical Society of Wisconsin, held at the Society's headquarters, Madison, Wisconsin on Saturday, October 10, 1964, convened at 9:25 a.m., Dr. R. E. Callan, Speaker of the House, presiding.

Speaker Callan: You will recall that at its 1959 Session the House directed that each future session be opened with the reading of Article II of the Constitution, entitled "Purposes".

"The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

The House is a legislative body and its processes are democratic. No delegate should hesitate to present his views. By precedent, discussion has been limited to five minutes for each speaker and may be extended by permission of the House. Each member is requested to give his full name and the county society he represents when he addresses the Chair.

REFERENCE COMMITTEE APPOINTMENTS

Announcement of reference committee appointments is made at this time. I have appointed the following reference committees:

To the Reference Committee on Reports of Officers:

C. J. Strang, M.D., Barron, Chairman
H. F. Twelmeyer, M.D., Wauwatosa
F. M. Hilpert, M.D., Racine
M. V. Overman, M.D., Neillsville
Robert Monk, M.D., Waukesha

To the Reference Committee on Reports of Standing Committees:

W. T. Russell, M.D., Sun Prairie, Chairman
G. W. Hilliard, M.D., Milwaukee
W. F. Henken, M.D., Racine
C. A. Grand, M.D., Ashland
D. J. Twohig, M.D., Fond du Lac

To the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws:

T. J. Nereim, M.D., Madison, Chairman
E. P. Rohde, M.D., Galesville
B. P. Waldkirch, M.D., De Pere
D. R. Griffith, M.D., Eau Claire
G. E. Collentine, Jr., M.D., Milwaukee
Non-voting members:
L. W. Schrank, M.D., Waupun
C. J. Picard, M.D., Superior

REPORT OF CREDENTIALS COMMITTEE

The Committee on Credentials is composed of Doctors D. J. Carlson, Milwaukee, chairman; W. D. Hamlin, Mineral Point, and J. W. Boren, Jr., Marinette. Is Doctor Carlson, the chairman, ready to report?

Dr. D. J. Carlson (Milwaukee): The Committee on Credentials has verified the registration of 46 delegates and 6 alternate delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend:

Dr. Joseph F. Kovacic for Sheboygan County
Dr. Dale R. Shampo for Richland County

I move that the attendance roll of delegates, alternate delegates, and specially appointed delegates, totaling 52, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

APPROVAL OF 1964 ANNUAL MEETING PROCEEDINGS

Speaker Callan: The next order of business is approval of the minutes. The minutes of the May 1964 Annual Meeting are in the September issue of the WISCONSIN MEDICAL JOURNAL beginning at page 393.

There is one technicality. The Speaker received the JOURNAL yesterday and did not have time to peruse it. I wonder if all the delegates have had access to the JOURNAL and have read the minutes. Is there any discussion of that point?

If you wish to approve the minutes as printed, I have approved along with the Secretary the summary of transactions that you received after the last House of Delegates meeting, and I am sure the minutes are correct as printed; but the minutes may not have been available to all the delegates.

What is your pleasure?

Dr. H. M. Suckle (Dane): I move they be approved as printed.

[Motion seconded and carried.]

ADOPTION OF STANDING RULES

Speaker Callan: The next item is the adoption of standing rules. Standing rules of procedure are stated on pages 2 and 3 of the House of Delegates Calendar. Is it the pleasure of the House that these rules be adopted as the standing rules of this session?

Doctor Carlson: I so move.

[Motion seconded and carried.]

Vice-Speaker G. A. Behnke: We will now proceed to the reports of officers. May we now hear from President Curran.

■ REPORT OF THE PRESIDENT—OCTOBER 1964

President W. P. Curran: Approximately five months have passed since I have had the honor to speak to you as your President. This period of time has passed rapidly and a great deal of work has been accomplished. Your committees are meeting as scheduled, with some exceptions, and I understand that there are 60 to 80 meetings a year. They are doing a good job for the profession and the State.

National meetings have been attended by your elected representatives, and reports have been and will be made available to you on matters of interest to all of us. To the best of my knowledge and observation, the staff is doing its usual commendable job for us all.

In my remarks to you in May in Milwaukee I stressed the thought of communication to you physicians of all matters of vital interest to us and the people we care for and serve. I told you at that time that if we are all well informed in all ways we can do a better job for our patients, the public and ourselves as physicians and members of the State Society in both a professional and legislative manner. Today I again want to reemphasize my belief in the importance of communication.

To illustrate its importance, today in Wisconsin and throughout the nation there are thousands of people who are eligible for hospital and medical care but who do not know of this fact because no one has informed them of their privileges. In my own experience in the past three months several people have been cared for under Kerr–Mills, or HAPA, because a physician took time to tell them what arrangements could be made for them to receive the care they needed.

We are in a position to do a great service to the public in this respect and gain good will and gratitude as physicians which we are sorely in need of public relationswise.

It seems as though there is a move afoot to discredit Kerr–Mills and to publicize all the good that can come to people from medical care under social security, to the people who are so-called senior citizens. Some of you may have seen the ridiculous campaign material presented to these people over television recently. The illustration shows a social security card being torn up, to show what will happen to social security if so-and-so is elected President of the United States.

I think it behooves us to tell our patients and friends that the illustration is not too far-fetched if medical care is to be financed through social security funds. I am amazed at the number of people who do not have factual information on this subject and who are literally begging for someone to tell them the truth.

Whether we realize it or not, let me remind you that organized medicine is fighting for its political life; and the earlier we tell the people who vote our side of the story, the better chance we have of being able to continue to practice medicine as we know it, rather than under the circumstances that our fellow physicians in England, Canada, and other areas are forced to in caring for their patients.

Let's have more effort on our part to tell our story, physician to patient, physician to service club; and less ineffectual bitching about how things are going on a national level, so that we and our patients will be much better off.

Our relations with the paramedical groups in Wisconsin are on a satisfactory level. There are minor differences to be ironed out, and these will be cleared through the aid of meetings between physicians and these groups. Frequent meetings on a higher level do more to clear the air than hundreds of letters.

I am satisfied with my tenure of office thus far, and I believe that in the months between now and May 1965 the good work by all will continue and will be a source of satisfaction to you and to me.

As your President I have the honor to read a letter to you from Mrs. John Satory, President of the Woman's Auxiliary to the State Medical Society of Wisconsin. The letter is addressed to Doctor Curran and Doctor Fox and the House of Delegates and reads as follows:

"Why are you here? Not only do I ask, but ask yourself: 'Why am I here?' For whatever reason you are here, the Woman's Auxiliary of the State Medical Society of Wisconsin exists. We are your Auxiliary but we are now asking you to assist us.

"Should not every doctor's wife be an Auxiliary member? Is she not concerned with the best interests of her husband's profession? It is the aim of the National Auxiliary to attain 100 per cent membership in the next five years. Are you willing to assist the Wisconsin Auxiliary to be there?

"Let me refresh you, the leaders of the State Society, about some of the things the State Auxiliary, composed of your wives, has accomplished.

"Last year we gave $7,147.91 to AMA-ERF, part of a national figure of $307,318. One Wisconsin auxiliary of about 20 members gave 11 scholarships totaling $1,100. This alone warrants Auxiliary membership.

"However, many hours of service were given to blood banks, vaccine clinics, cancer dressings, international health, medical histories and, last but not least in results, legislation.

"Please go back to your county societies and ask your co-member, 'Was your wife there? If not, why not?'

"We need your help. In areas of membership problems the answer is, 'My husband couldn't care less.' They want to know why.

"Who can be a better liaison for the profession than your wife, an informed Auxiliary member?

"Sincerely yours,

"Mrs. John Satory."

■ REPORT OF THE COUNCIL—OCTOBER 1964

Vice-Chairman John M. Bell (Marinette): Doctor Fox was prevented from being here this morning because of an emergency in his own practice.

I am grieved to inform you that Todd Koenig, the three and a half year old son of one of our principal employees, Mr. Ray Koenig, our insurance director, drowned yesterday morning. I wish the House would stand for a moment of silent prayer because of this great tragedy.

[Silent standing tribute to the memory of Mr. Koenig's son.]

[Doctor Bell then presented the report which appears at page 587 of this issue.]

■ REPORT OF THE SECRETARY—OCTOBER 1964

Secretary C. H. Crownhart: If I were the principal executive officer of a stock corporation formed for the profit of the stockholders, I think I would phrase my report to you today in a somewhat traditional fashion of telling you and reminding you that we are an old corporation and that our interests, our activities and our responsibilities have increased through the years to the point where they are now quite tremendous.

I would be proud of the quarterly dividends that had been paid the stockholders.

I would point with pride to the fact that at the end of the fiscal year we were able to send you a check for an additional dividend because of the work done, and I would tell you that the board of directors had authorized the dividend to be increased on a regular basis in the next fiscal year.

I would have charts to demonstrate growth. I would have the dollar cut up in a number of pies of varying sizes, and after applause on the basis of the dividends paid in the past year and the dividends to be paid in the next year you would happily go to a meeting room where coffee and doughnuts would be served and the "brass" would be there to greet all of you.

But this being a nonprofit corporation, dividends cannot be returned on your investment in it in the form of something by way of cash results. Yet I think it can be said that the dividends in the interest of public health during this year and the year preceding have been very measurable. They are dividends in which you can take real interest, and they demonstrate the solid organization of the profession.

To illustrate the point, I would like to emphasize that HAPA, the implementation of Kerr–Mills in Wisconsin, requires that the State Department of Public Welfare see that physicians and other providers of health service be paid a usual, reasonable and customary charge, and liaison is being rapidly established both with Continental Casualty and the State Department of Public Welfare to see that the requirement of the law is carried out.

The dividend can be expressed as one of pride on your part that your services will receive the same kind of consideration as other services provided those in need of some assistance.

In the long run the discount imposed upon physicians in the area of public assistance and discriminating against them but not against those who provide rental facilities and coal and fuel oil, will most possibly be eliminated.

In another area I can tell you that there are dividends in the legislative end involving optometry. Optometry has great ambitions. During the last legislative session it offered an extensive program, only one provision of which was passed. That provision says in effect that state departments of public welfare shall recognize the provision of services by optometrists on the same basis that they would those provided by physicians in the ophthalmology field.

That provision has been interpreted only as meaning that welfare officials and public officials in other areas can recognize the services of optometrists and authorize them. But the optometrists have now started a program to say that, because of that, they must be paid the identical dollar benefit that would be paid an ophthalmologist.

We are in the process (and I am sure it will be successful) of pointing out that you don't pay the same thing for apples and oranges. The optometrist is a technician. He cannot use drugs in refraction of the eyes, and he has other limitations, while the ophthalmologist does not.

And so we say to the county departments of public welfare and state officials that of course you can pay more for the services of ophthalmologists, because they give more than do the optometrists.

I think we can point to dividends arising out of the Wisconsin Work Week of Health that have been literally tremendous. The program format, as you possibly recognize, is unique in the development of a format for a program of any type because there is much informative text included. The resolutions of the Society in various areas of public welfare and scientific medicine and health accomplishments are facing tests to the program itself.

In February of this year there were possibly 1,500 people in the building. This posed some interesting problems. For the first time we hired a police force to handle parking outside. But those people were here, and most of them were lay people, most of them representing substantial interests and substantial numbers of people from the vicinity from which they came.

Some 15,000 copies of the program were submitted to civic leaders throughout the State, to the Supreme Court judges, circuit judges, county judges (I always mention the lawyers, I don't know why), to public welfare officials, welfare agencies, and many, many other groups throughout the State. It set a fine precedent. It proved eminently satisfactory in translating the viewpoints of Wisconsin medicine to those having interests allied with it.

In the area of the Charitable, Educational and Scientific Foundation, its dividends to the public and to you in the profession have, I think, proved quite successful. For example, between an appropriation of $3,000 from your dues structure and the added donation of $3,000 from Western Printing Foundation of Racine, the Menominee Indian Study was made and the recommendations of that Study are before you for implementation in the future. Here is the first concrete study that has been made of the public health problem in Menominee County. The Indians there have had survey after survey. They are rather tired of surveys, and they would like to see some action taken.

One recommendation of the Study Committee was that a scholarship fund be established for the residents of that County (young people, of course) who might be interested in pursuing careers in paramedical fields and others relating to the health of the people of the county. We are pleased that through the action of an interested person in this State, $3,000 has been donated to the Foundation and a $500 loan has already been executed. We hope that further funds will be achieved.

The Foundation has received approximately $37,000 from surplus SOS funds in the State. It welcomes more. These funds are being set up in a fashion so that in more or less equal amounts they will finance the professional education of nurses, dentists and pharmacists as well as physicians. It is a substantial result of a substantial activity.

I emphasize to you that in this past year we achieved the interest of a corporation in our activities in the Foundation, to the extent that it has pledged $40,000 to be transmitted to the Foundation this year, next year and the year following. The first payment of the $40,000 has already been made, and that amount is earmarked for the purpose of the Medical Museum at Prairie du Chien which is now under total operation of the Foundation, with the cooperation of the State Historical Society.

The exhibit here is not as yet complete, but it is estimated that it will be up 10 to 15 per cent over last year. We are greeting some 3,000 high school students even from as far away as Dodge County, who came over in May to see the exhibit as part of their class-day ceremony.

Only within the week the director of the postgraduate medical education program at the University of Missouri, Columbia, not only complimented the Foundation and the operations at Prairie du Chien but said that one of the outstanding impressions was that of the Bohrod paintings; and he requested that they be loaned to the University of Missouri for exhibit there during a week or so of postgraduate training.

So, the activities of the Foundation are now extending as originally planned, beyond the borders of the county and the State; and in the ensuing five years I think you will see a very active demonstration of the need and value of the Museum of Medical Progress.

I have spoken to you thus far from notes I have made during the week, but I have a page I am going to read to you.

> "On repeated occasions we have stated our legislative policy in Wisconsin to be that whatever is best for the health of the public is by that fact

best for physicians. Health knows no politics and no creed. Those who serve the need of our people must be competently trained and, if limited in their licensure, should not seek expansion of privilege without first demonstrating commensurate educational advances. Yet they do so.

"Optometry fought a long and exhaustive battle and is still at it. Chiropody became the subject of a Supreme Court case because of its contentions. The State Medical Society's views were upheld by the Court and its decision has been mailed to every member, for it is a significant milestone in determining the status of the limited licensee.

"Chiropractic was held to an active legislation session without victory. But I sense new strategy. The Republican candidate for State Senator in the Madison district is a chiropractor. He inched his way along the political trail by becoming Chairman of the Republican Party here in Dane County. He opposes Democratic State Senator Risser, who has served the public health well. The latter's record on quackery legislation is equally fine, as is that of his colleague, Senator Carl Thompson of Stoughton. Discussing this point, I am reminded that Congressman Mills, himself a Democrat, is greatly credited with the current defeat of King–Anderson legislation.

Public health and medicine can find no comfort only in the area of political faith but in the area of men who put health above politics."

Concluding this report, on behalf of the staff we subscribe to a statement made by President Elvehjem at the time of his inauguration, when he said:

"Our goals must be linked closely with the welfare of Wisconsin people; our methods must be above reproach; our service must be total, dedicated, and selfless. These things I pledge to work for with all the strength at my command. For with broad-ranging support we can turn the educational challenges of tomorrow into advantages for all society.

"Give us, then, the hills to climb and the strength to climb them."

Vice-Speaker Behnke: Are there any further supplemental reports?

REFERRAL OF REFERENCE COMMITTEE REPORTS

So that the delegates may be advised as to which reference committee will hear the various reports and recommendations submitted, this announcement is made on the subject.

Where the subject matter is related, your Speaker has made every effort to refer those matters to the same reference committee.

To the Reference Committee on Reports of Officers:

Council Report No. 3 (except the resolutions).
Commission on State Departments and Division on Nervous and Mental Diseases—Nos. 1 and 1-a.
Menominee County Health Survey.

To the Reference Committee on Reports of Standing Committees:

Commission on Medical Care Plans—No. 2.
Commission on Hospital Relations and Medical Education—No. 4.
Resolution 11 by Dodge County re HAPA.

To the Reference Committee on Resolutions:

Resolutions Nos. 1 through 10 by the Survey Committee.
Resolution No. 12 by Dane County.
Resolutions Nos. 13 and 14 by the Council (for introduction only.)
Dues for 1965, also the proposed budget.
Supplemental Reports A, C, D and E of the Council.

Speaker Callan: It is a privilege as well as an opportunity for any interested member of the Society to appear before these reference committees and present his views on any matter properly before them. Delegates who are interested in any particular matter are especially urged to be present.

The highest overhead we have, although it is not catalogued in our budget, is the professional time that you gentlemen are using now. Although the delegates' bulletin says that the reference committees will meet at 1:30 p.m., a few hours from now, and that there will be a second session of the House tomorrow morning, it might be appropriate to consider whether the reference committees can start meeting now and thus gain a few valuable hours. However, since the schedule is now printed, it would seem only fair to protect the Society and the interests of minorities and, if it is the wish of the house, adopt this time change by a two-thirds vote. What is your pleasure?

Dr. C. J. Picard (Douglas): I move that we begin the reference committee meetings now.

[Motion seconded.]

Dr. B. P. Waldkirch (Brown): Is there no intent to change the meeting set for tomorrow morning?

Speaker Callan: If the work is done, it would seem reasonable that there would be no meeting tomorrow morning. That brings up another point: Are there any alternate delegates who are planning to be here tomorrow to substitute for someone here now, thinking that the business will go on tomorrow? That is why any change should be by official act of the House. Is there any other discussion of the motion?

[Motion carried.]

Speaker Callan: The reference committees will meet immediately upon adjournment of this session.

Dr. L. W. Schrank (Dodge): How will we know, if we conclude the reference committee meetings early, that the next session of the House will be called this afternoon? What will be done?

Speaker Callan: It would seem that before adjournment the House should set a time for the next session.

Doctor Schrank: I move we set the next session for 3 p.m.

[Motion seconded.]

Speaker Callan: Three o'clock may not give the reference committees too much time. We don't know how much time they will need.

Dr. T. J. Nereim (Dane): In writing a report considerable time is sometimes required. I think three o'clock would press the various committees too much. A year ago the reference committee that I chairmaned wound up its work at four o'clock in the morning, and the House meeting started at 7 p.m. I think three o'clock is a little unrealistic.

Dr. E. L. Bernhart (Milwaukee): I would like to amend the motion, that we reconvene at 7:30 p.m. this evening.

[Motion seconded.]

Speaker Callan: All delegates have been reminded by the Secretary's office of that provision of the Bylaws providing that all new business first introduced at this time must be introduced through the Council, constitutional officers, committees of the Society or of the House, or officers of the House.

Is there any further business properly to come before the House at this time?

Secretary Crownhart: I think I should advise you, in light of some atmosphere that I seem to detect here, that we have present both our General Counsel, Mr. Murphy, and Associate Counsel, Mr. Kluwin, of Milwaukee. The C.P.A.s are represented by Mr. White; and Mr. Tiffany, our consulting actuary, is here.

Speaker Callan: If there is no further business, we will stand adjourned until 7:30 p.m. this evening.

[House adjourned at 10:15 a.m.]

SATURDAY EVENING SESSION

October 10, 1964

The second session of the House of Delegates convened at 7:45 p.m., Dr. R. E. Callan, Speaker of the House, presiding.

Speaker Callan: The first order of business is the report of the Credentials Committee.

REPORT OF CREDENTIALS COMMITTEE

Doctor Carlson: The Committee on Credentials has verified the registration of 44 delegates and 7 alternate delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed that the following will act as delegates for the regular delegates and alternates who are unable to attend:

Joseph F. Kovacic, M.D., for Sheboygan County

Dale R. Shampo, M.D., for Richland County

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 51, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

■ REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Vice-Speaker Behnke: The first reference committee to report this evening will be the Reference Committee on Reports of Officers, composed of Drs. C. J. Strang, Barron, chairman; H. F. Twelmeyer, Wauwatosa; F. M. Hilpert, Racine; M. V. Overman, Neillsville, and Robert Monk, Waukesha.

Dr. C. J. Strang: Your Reference Committee on Reports of Officers has reviewed the report of the Council of October 1964, with the exception of Resolutions Nos. 13 and 14, as well as Supplementary Reports B and F.

This Reference Committee notes with satisfaction the recent Supreme Court decision in the case of the State Medical Society of Wisconsin vs. Charles Manson, Commissioner of Insurance. The solution of the Town and Gown problem is being actively implemented. Attention is called to the reports being made to the Council on the study of alcoholism, and further efforts along this line are urged.

Supplementary Report B of the Council was reviewed, and your Reference Committee recommends adoption of the report of the Planning Committee on Osteopaths and Postgraduate Training. It also recommends releasing the proposed bulletin to all presidents and secretaries of the county medical societies with a suggested change. Your Reference Committee feels that the last paragraph should read as follows:

"Biographical data satisfactory to your local county medical society should be secured from osteopaths in your area before they are placed on a list of those acceptable."

Your Reference Committee concurs with the Council suggestion that Supplementary Report F be referred to the Commission on Public Policy with instruction that it report back to the Council. It is recommended by the Reference Committee that the present law, Chapter 147, Section 147.13, remain unchanged.

Your Reference Committee recommends that the report of the Council and its Supplementary Reports B and F be adopted. I so move.

[Motion seconded and carried.]

Doctor Strang: The Menominee County Health Survey Report was reviewed. This Reference Committee commends the Menominee County Study Committee and particularly Martha R. Jenny, R.N., for outstanding and comprehensive field work. It was pointed out that Miss Jenny personally interviewed each family in the County.

While it is recognized that pressing economic and housing needs are beyond the scope and purpose of this project, it is recommended that this information be made available to the appropriate private and governmental agencies for help in correction of the underlying economic problems.

Your Reference Committee recommends that the Menominee County Health Survey Report be adopted. I so move.

[Motion seconded and carried.]

Doctor Strang: The report of the Commission on State Departments was also reveiwed, and your Reference Committee is in agreement with the projects and plans outlined for the various divisions. It notes with regret the recent death of Milton Feig, M.D., State Board of Health representative to the Divisions on Aging and Chest Diseases.

The Reference Committee would like to add further emphasis to certain areas of the report and suggests that the Society go on record (for reasons given in the report) as opposed to compulsory testing for phenylketonuria. Furthermore, it should be recommended that no nurse nor therapist dealing with handicapped children should administer medication of any type without proper physician instruction.

The Reference Committee also recommends continued study by the Division on Public Assistance of the fee schedule problems of programs administered by welfare departments, and requests that a further report be made to the House of Delegates in May 1965.

Your Reference Committee recommends that the report of the Commission on State Departments be adopted. I so move.

[Motion seconded and carried.]

Doctor Strang: The report of the Division on Nervous and Mental Diseases was also reviewed. Your Reference Committee recommends its adoption. I so move.

[Motion seconded and carried.]

Doctor Strang: Your Reference Committee further recommends acceptance of the reports of the President and Secretary made at the opening session of the House. I so move.

[Motion seconded and carried.]

Doctor Strang: I now move for the adoption of the report of the Reference Committee on Reports of Officers as a whole.

[Motion seconded and carried.]

■ REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Vice-Speaker Behnke: The next reference committee to report is that on Reports of Standing Committees. Its Chairman is Dr. W. T. Russell of Sun Prairie. Other members are Drs. G. W. Hilliard, Milwaukee; W. F. Henken, Racine; C. A. Grand, Ashland, and D. J. Twohig, Fond du Lac.

Dr. W. T. Russell (Dane): Your Reference Committee on Reports of Standing Committees reviewed Resolution No. 11 and appreciates the interest of the Dodge County Medical Society in bringing to the Society's attention the use of the word "vendor" in administration of HAPA. Your Reference Committee recognizes the fact that the term has been used as a convenience and was not intended as a term derogatory to the medical profession. It has received information that the problem is under consideration by the State Department of Public Welfare, and we have the assurance that a proper correction will be made in the new edition of the Manual.

Your Reference Committee recommends that in negotiations with the State and the insurance company, professional services be recognized as such through following the wording of the law itself, which provides among the benefits "professional services performed by a physician or a doctor of dental surgery".

On this basis, your Reference Committee recommends rejection of Resolution No. 11. I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Russell: Your Reference Committee reviewed the report of the Commission on Medical Care Plans and heard testimony from Dr. E. M. Dessloch, Chairman of the Commission, in reference to the report. It is noted that a 15½ million dollar premium income objective is well on its way to being realized, in that earned premiums of $8,694,609 through July of this year were $1,233,964 higher than for the same period in 1963. It is further noted that with increased utilization of all health care benefits, rate adjustments continue to be necessary to maintain a sound balance.

Your Reference Committee commends the Commission on its promotional campaign under the theme of "Tickets to Protection" and the use of direct mail to a half-million Wisconsin homes. Both the dental and senior citizens' contracts are receiving accelerated impetus and attention, with a 12 per cent increase noted in the Century Plan contracts.

The Commission is further commended on its continued efforts to find a solution to the desire of the members of the radiology and pathology groups to be treated as independent private practitioners, and for its action in insisting on the payment of usual, customary and reasonable charges for services rendered under the Medicare and Veterans Administration programs.

It is noted that the Commission continues its efforts to look to the future so it may be ready when medical, social, technological, even political breakthroughs occur which affect the WPS product and market, keeping it alert to its avowed purpose of being the pioneer in health care coverages.

Your Reference Committee recommends acceptance of the report of the Commission on Medical Care Plans as presented. I so move.

[Motion seconded and carried.]

Doctor Russell: Your Reference Committee reviewed the report of the Commission on Hospital Relations and Medical Education and heard testimony from its chairman, Dr. George B. Murphy of La Crosse.

The Reference Committee concurs with the Commission in its recommendation regarding Resolution No. 24 introduced by the Manitowoc County Medical Society in May, which is to the effect that medical staffs of Wisconsin hospitals are urged to comply as best they can with the principles enunciated by the Joint Commission on Accreditation of Hospitals, and that no further action be taken at this time regarding the resolution.

It was noted by Doctor Murphy that the Commission had reconsidered the desirability of dividing into two subcommittees, one on hospital relations and the other on medical education, and rejected this proposal in view of the fact that the deans of the medical schools expressed a desire to continue working with the Commission as a whole.

Your Reference Committee commends the Commission for its action in implementing Resolution No. 22 of last May relative to Town-Gown Symposia under the more appropriate title of Conferences on Medical Education and the Practice of Medicine in Wisconsin.

Your Reference Committee notes with interest that the Commission is planning a program on emergency care in the general hospital, to be part of the Wisconsin Work Week of Health to be presented during the week of February 22, 1965.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Russell: I now move adoption of the report of the Reference Committee on Reports of Standing Committees as a whole.

[Motion seconded and carried.]

■ REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Speaker Callan: The last reference committee to report is the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. Members of the Reference Committee are: Drs. T. J. Nereim, Madison, Chairman; E. P. Rohde, Galesville; B. P. Waldkirch, De Pere; D. R. Griffith, Eau Claire; G. E. Collentine, Jr., Milwaukee; and as non-voting members, Drs. L. W. Schrank, Waupun, and C. J. Picard, Superior.

Dr. T. J. Nereim (Dane): In open hearing this morning and in executive session this afternoon, your Reference Committee on Resolutions reviewed the important resolutions and matters referred to it.

Your Reference Committee recommends the acceptance of Resolution No. 1, introduced by the Survey Study Committee, with revisions in the first two Resolved clauses. The resolution would now read:

> "WHEREAS, the House of Delegates is the governing body of the State Medical Society of Wisconsin, incorporated under Act 53 of the Territorial Laws of 1841 which chartered this Society and gave legislative sanction to the Constitution and Bylaws as originally created, and as such is the only body with the authority to amend this Constitution and these Bylaws and, furthermore, possesses certain fundamental inherent rights that are not altered by the subsequent general law covering non-stock corporations, and
>
> "WHEREAS, the Council of the State Medical Society of Wisconsin, under Article VI shall be the Board of Trustees of this Society and shall have full authority and power of the House of Delegates between sessions; now, therefore, be it

"*Resolved:* That Article VI be interpreted as granting the Council the authority to enforce the Constitution and Bylaws but not to change or alter them; and be it further

"*Resolved:* That Article VI be interpreted as granting the Council the authority to determine its own committee structure and the membership of these committees to best serve the interests of the Society, and to engage the Secretary-General Manager and his principal assistants through contracts of employment, and adopt necessary regulations in management; and be it further

"*Resolved:* That in Chapter VI, Section 1 of the Bylaws stating that the Chairman of the Council shall make an annual report to the House of Delegates, it be interpreted as implied, that this report shall include all major actions and policy decisions, and that this report shall be subject to approval by the House of Delegates; and be it further

"*Resolved:* That this resolution and all other resolutions pertinent to or explanatory of any portion of the Constitution and Bylaws be hereinafter designated as an annotation to the sections to which they apply."

I move acceptance of this portion of the report. [Motion seconded and carried.]

Doctor Nereim: Your Reference Committee points out that Resolution No. 2, also introduced by the Survey Study Committee, calls for development of the positions of Assistant Secretary in Scientific Medicine and Insurance Director. Since these two staff positions are filled, we recommend acceptance of the resolution in the following revised form:

"*Resolved:* That the chief executive officer of the State Medical Society shall be the Secretary-General Manager. He shall be engaged by the Council as provided by the Constitution and Bylaws and shall be responsible for the operation of the State Society office. He shall be charged with the execution of policy without assuming policy-making power and shall assist the officers in making decisions and taking actions, share his convictions and argue their merits as requested, and acquaint the officers, Council and House of Delegates with the need of change; and be it further

"*Resolved:* That the Secretary-General Manager, in collaboration with the Council, make every effort to develop the positions of assistant secretaries as full-time positions with adequate salary and appropriate authority in the structure of the State Society Office; and be it further

"*Resolved:* That the question of the status of the chief executive officer as a member or officer of the Society be considered by the Council in the future when selecting a successor to the Secretary-General Manager."

I move acceptance of this portion of the report. [Motion seconded and carried.]

Doctor Nereim: In consideration of Resolution No. 3, offered by the Survey Study Committee, your Reference Committee wishes to amplify it as follows:

"*Resolved:* That the House of Delegates recommend to the Council that it annually review the services of general counsel, legislative representative, auditor, actuary, investment, and other consultants with consideration of the extent of their utilization, the efficiency of their services, and the propriety of their charges; and be it further

"*Resolved:* That this information be available to the membership through its Councilors."

I move acceptance of this portion of the report. [Motion seconded.]

Dr. R. A. Straughn (Dane): It reads: "this information be available to the membership through its Councilors". What is the implication in terms of the necessity? Is the Councilor responsible for all such information being made available to the members, or does it mean only that it may be available to the members?

Doctor Nereim: If the information is desired, it is secured through this channel.

[Motion carried.]

Doctor Nereim: Resolution No. 4 introduced by the Survey Study Committee, deals with terms of office in county medical societies. Your Reference Committee is in favor of this resolution and recommends its acceptance as presented. I so move.

Dr. F. E. Drew (Milwaukee): Does this cover the entire resolution—the first paragraph you are reading?

Speaker Callan: It is Resolution No. 4 as presented.

Doctor Nereim: It isn't all included in this report.

Speaker Callan: The Reference Committee is in favor of Resolution No. 4 and recommends its acceptance as presented, unchanged. Does that answer your question?

Dr. Joseph F. Kovacic (Sheboygan): This afternoon it was brought out that the word "recommended" makes it not mandatory. Is that still in effect?

Speaker Callan: Yes, that is understood.

Doctor Drew: Going back to what I said this morning concerning our operating under a separate charter: Does this apply to us?

Speaker Callan: It is a recommendation by the House of Delegates, if passed, to all county societies. It is a recommendation, not a directive.

Doctor Drew: I realize that, but that is sort of bypassing the issue. In other words, if the House should come up with a recommendation that our officers would have certain terms of office, would that apply to us in particular because we operate under a separate charter?

Speaker Callan: The Chair would interpret it to mean that you can take the recommendation or not take it.

Doctor Drew: This isn't quite clear. That is why I posed the question. I think we should have the delegates tell us whether or not we should abide by this. In other words, if this matter as it is written now would set up certain terms of office, I am of the opinion that it would apply to us because we are a part of the State Medical Society.

Speaker Callan: Doctor Drew, I don't feel the recommendation goes that far.

Doctor Drew: I would like to have concrete evidence that it does not exactly apply to us.

Speaker Callan: Is Doctor Griffith, chairman of the Survey Committee, here? Doctor Houghton, would you care to comment on this question?

President-Elect J. H. Houghton (Sauk): Since Milwaukee County is a part of the State Medical Society, I believe the thinking of the Survey Committee was that this would apply to Milwaukee County in the form of a recommendation, not as a directive, the same as it applies to every other county medical society. This is a recommendation. You can do it or you don't have to do it. It goes for every county.

Doctor Drew: Okay; that's all I wanted to know. Thank you.

[Motion carried.]

Doctor Nereim: The important subject of districting is taken up in Resolution No. 5, also offered by the Study Committee. With changes recommended

by the Reference Committee, it would read as follows:

"WHEREAS, the present method of districting is not equitable and deserves further study, and

"WHEREAS, redistricting is a tremendous problem in itself and one which requires undivided attention and consideration by a group not involved with other problems; now, therefore, be it

"*Resolved:* That a special ad hoc committee of the House of Delegates be appointed consisting of ten members, one from each congressional district. This committee shall have the task of studying the subject of redistricting as it pertains to the House of Delegates and to the Council, and shall report its progress to each session of the House of Delegates until final conclusions are reached; and be it further

"*Resolved:* That this committee shall be appointed by a committee composed of the President, the Chairman of the Council, the Speaker and the Vice Speaker of the House of Delegates."

I move acceptance of this portion of the report. [Motion seconded and carried.]

Doctor Nereim: Your Reference Committee feels that Resolution No. 6, introduced by the Survey Study Committee, dealing with committee appointments, serves no useful purpose and should be rejected.

I move acceptance of this portion of the report. [Motion seconded and carried.]

Doctor Nereim: In studying Resolution No. 7 of the Survey Committee, your Reference Committee concluded that the matter of dues should be deleted in this resolution because it is taken up later. It also felt that the provision of a full-time manager for the CES Foundation should not be delayed until "financially feasible." Therefore, it recommends the acceptance of Resolution No. 7 in the following revised wording:

"WHEREAS, the Charitable, Educational and Scientific Foundation, in addition to the Museum of Medical Progress, is providing substantial sums to medical students at low interest rates and is responsible for the greater portion of postgraduate medical education in the form of honoraria and expenses to speakers, and is giving financial aid to indigent physicians and their families, and

"WHEREAS, from the annual report the over-all analysis of cost and functions appears to be favorable, and

"WHEREAS, it appears that there is a great lack of understanding by physicians concerning all the functions as well as the needs of the Charitable, Educational and Scientific Foundation; now, therefore, be it

"*Resolved:* That the Charitable, Educational and Scientific Foundation continue to operate for the best interests of the public through its programs of aid to medical students, postgraduate education, and aid to physicians in distress, and that it improve its reporting to the physician membership so that its functions are better understood; and be it further

"*Resolved:* That thought be given to providing a full-time manager for the Foundation."

I move acceptance of this portion of the report.

Doctor Drew: May I have clarification of the word "thought" in the final Resolved?

Doctor Nereim: I suppose what the Committee had in mind was that it should be further considered before something is done.

Doctor Drew: Does that mean that the Committee recommends that we proceed? I think it is a little difficult to interpret the word "thought" as it now appears in the sentence. It is either Yes or No.

Doctor Nereim: I think they had the idea of planning for the future, rather than immediate action.

Doctor Drew: Would you consider changing the word "thought" to "consider"?

Speaker Callan: The delegate may make an amendment if he so desires.

Doctor Drew: I move that it read: "*Resolved:* That consideration be given to providing a full-time manager for the Foundation."

[Amendment seconded and carried]

[Motion as amended was carried.]

Doctor Nereim: The Survey Study Committee also introduced Resolution No. 8, which deals with the SMS Realty Corporation. Your Reference Committee recommends its acceptance as presented. I so move. [Motion seconded and carried.]

Doctor Nereim: Resolution No. 9 of the Survey Study Committee is recommended for acceptance with modification in the second "WHEREAS" clause. In its entirety it would then read:

"WHEREAS, detailed study of the Booz, Allen and Hamilton report revealed certain criticism of the Secretary and staff of the State Medical Society that has proven to be due to lack of understanding, and

"WHEREAS, the reasons for other elements of criticism have in large measure been overcome, and

"WHEREAS, the Survey Committee has received willing cooperation in the entire study; therefore, be it

"*Resolved:* That the House of Delegates express its confidence in the sincerity, integrity and ability of the Secretary and staff of the State Medical Society."

I move acceptance of this portion of the report. [Motion seconded and carried.]

Doctor Nereim: The last of the resolutions offered by the Survey Study Committee relates to the Booz, Allen and Hamilton report itself, and is Resolution No. 10. Your Reference Committee recommends its acceptance in the following revised form:

"WHEREAS, the Program and Management Survey provided by Booz, Allen and Hamilton has served as a useful stimulant in the revision of our procedures and the improvement of our operations; now, therefore, be it

"*Resolved:* That the Booz, Allen and Hamilton report be placed on file and that the House of Delegates express the great appreciation of the Society to the Survey Study Committee for the masterful analysis and program of action which it presented to this Society; and be it further

"*Resolved:* That this Committee now be discharged." I move acceptance of this portion of the report. [Motion seconded and carried.]

Doctor Nereim: Your Reference Committee considered Resolution No. 12 of the Dane County Medical Society and Supplementary Report (A) of the Council together, since they deal with the same subject. In substitution of these two resolutions the following is recommended:

"WHEREAS, the State Medical Society of Wisconsin, in accordance with Article II of its Constitution, has among its purposes, in existence for 123 years, the extension of medical knowledge and advancement of medical science and to elevate the standard of medical education; therefore, be it

"*Resolved:* That the State Medical Society joins in strong support of efforts to obtain a Dean of the University of Wisconsin Medical School who is a physician experienced in the provision of medical care in the environs of a teaching hospital, who might be expected to emphasize the educating of clinical physicians for the State of Wisconsin while encouraging the continuation of significant research among those so talented, and opportunities for postgraduate and refresher courses; and be it further

"*Resolved:* That the Council of the State Medical Society of Wisconsin urge the President and the Board of Regents of the University of Wisconsin to consider the procurement of a dean with such qualifications of primary importance."

I move acceptance of this portion of the report.

Dr. G. S. Kilkenny (Milwaukee): I would like to know why this does not include Marquette.

Doctor Nereim: Marquette is not included because Marquette is a private institution. The idea of including Marquette was thoughtfully considered, and Doctor Collentine concurred with the rest of the Reference Committee that, since Marquette is a private school, we could perhaps submit this information there for their information, but we can't alter their policy.

Doctor Kilkenny: I don't know whether you can call it a policy for the University of Wisconsin, either.

Doctor Nereim: We can try. It is a public institution.

Doctor Kilkenny: I think Marquette turns out doctors on the public as well as Wisconsin, and I think Marquette is now in search of a dean, and this information would be very timely to them. I feel it should be given to them.

Dr. B. P. Waldkirch (Brown): There is some difference between the two schools. The University of Wisconsin has been seeking a dean for a couple of years, so far without success. There is some thought that there is a lack of enthusiasm and proper energy in the search, whereas this does not apply to Marquette.

Doctor Kilkenny: I think there is some evidence. If you were on the inside you would know it. You don't know it; I do.

Doctor Carlson: Knowing some of the members concerned with the selection of a dean, Doctor Kilkenny, I think perhaps the committee so instructed is more than adequately clinically oriented as it relates to Marquette.

Doctor Kilkenny: I accede to Doctor Carlson. He is more cognizant of the facts than I am. I appreciate what he has said.

Dr. D. M. Ruch (Milwaukee): In keeping with what Doctor Carlson said, as a member of the liaison committee of The County Medical Society of Milwaukee County and the Medical School, I feel that every effort is being made, and I think they are clinically oriented.

[Motion carried.]

Doctor Nereim: Your Reference Committee recommends introduction at this time, for action in May 1965, of Resolutions Nos. 13 and 14 as presented in the report of the Council. I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Nereim: Supplementary Report of the Council (C) deals with the activities and costs of the Field Service, and your Reference Committee recommends its acceptance as presented. I so move.

[Motion seconded and carried.]

Doctor Nereim: Your Reference Committee next reviewed the plans for commemoration of the Society's 125th Anniversary in 1966, and recommends acceptance of Supplementary Report (D) of the Council as presented. I move acceptance of this portion of the report.

[Motion seconded and carried.]

Doctor Nereim: The final item for consideration of this Reference Committee was a proposed budget for 1965. This was reviewed in consideration of the establishment of dues; and, as proposed in that report, your Reference Committee recommends that the regular membership dues be increased by $10 per year, and that an additional voluntary $5 be billed for the CES Foundation. I move acceptance of this portion of the report.

[Motion seconded.]

Doctor Drew: We are right back where we started this morning. I don't know whom you are kidding. This $5 voluntary is not going to be collected. Either you make it mandatory or you take it out, one of the two.

I think it is ridiculous to try to kid anybody, because this will not work as it is suggested now. The members are going to slough off that $5. We either have to be men or mice. Either we make it $5 or we take it out. I don't want to go back and tell my members that there will be a voluntary contribution. We represent almost 1,500 members of the State Society, and 1,500 members at $5 each means $7,500. If you want to forget about it, fine; but I think some clarification of the word "voluntary" should be made at this time.

Doctor Bernhart: I move an amendment—that this be a $15 addition to our dues structure, without the "voluntary" being added, and that $5 to go to the CES Foundation.

Speaker Callan: The amendment is that the dues be raised $15 per year and that the $5 be given for the CES Foundation.

Dr. G. E. Collentine, Jr. (Milwaukee): It was the unanimous consensus of the Reference Committee on Resolutions that we were all opposed to compulsory charity. We feel that if it is not possible by a promotion of better understanding of the objectives and functions of the CES Foundation to persuade the members of the profession that a $5 voluntary contribution is justified, the Foundation should do without it.

I subscribe to this wholeheartedly, and I violently oppose voluntary charity made compulsory, just as much as I oppose taking care of old people under direction of the government under the social security system.

Doctor Straughn: I think Doctor Collentine has emphasized this, and the only reason I rise is because I fear if it comes to a vote there may be those who would not speak out and the amendment might be passed.

I think there is a very real risk here of losing many people who voluntarily give more than $5. I don't know the figures, but there are quite a few members of this Society who do give a fairly good sum. But there are a lot who aren't giving anything. If we can further encourage those people to recognize their obligation, we will have served the purpose of this resolution without forcing it down somebody's throat and making the others feel, "If they are going to do that, I will just meet the expected amount and no more."

I think this would be a big mistake. We can always raise the dues and surreptitiously send the money to the CES Foundation. [Laughter] This could be done, but I think we are not helping ourselves.

Dr. R. N. Allin (Dane): I strongly resent an assessment for charity.

Speaker Callan: Any other discussion of the amendment? The amendment is to increase the dues $15 per year but earmark $5 of it for the CES Foundation. Is there further discussion of the amendment?

Doctor Bernhart: In reference to Doctor Allin's attitude, may I say that California and other states have very definitely made a proposal concerning this matter of dues structure. In Wisconsin we sit idly by. I have sat as a delegate for many years and have listened to these viewpoints. I don't go along with the idea that we have a charitable attitude.

I think we have to make a very definite proposal to these people to do certain things, and I believe the membership as a whole will go along with it because this is a very necessary thing. If we don't make it compulsory we will never get anywhere. If we are going to do something we should do it with all our heart and soul.

Doctor Kovacic: May I go on record as saying I will not endorse a compulsory charitable donation.

Speaker Callan: You are in favor of the original resolution.

Dr. R. F. Lewis [Wood]: I would like to raise a question. As I sat in on the conference this morning I was not under the impression that the main function of the CES Foundation is charity. It was my impression that they give charity to poor physicians, but that their main function consists of education and research, and to me these are not necessarily charity.

I think this is an important function of the State Medical Society. I am not at all sure we should not match that financially some way.

Speaker Callan: Do you express an opinion as to whether it should be compulsory or voluntary?

Doctor Lewis: If the main function is charity, that is one thing. If the main function is not charity, that is something else. I don't understand it well enough to know what the principal function of this Foundation is.

Speaker Callan: It is called the Charitable, Educational and Scientific Foundation.

Doctor Drew: Reiterating what I said earlier, we must be either men or mice. We either have to say it is $10 or it is $15. If you let this go through as it now reads, you will give members a loophole on the voluntary deal and we will not raise the money we should. I would like to have it changed to read $15 per year.

We are in favor of this Foundation, but we are not in favor of not being definite about the cost of its operation. I don't see why we should dodge this. Either have it or don't have it, one or the other.

Dr. D. R. Griffith [Eau Claire-Dunn-Pepin]: I don't believe the issue at stake is whether or not the CES Foundation is a worthwhile organization, nor whether or not it deserves support. It certainly is a worthwhile Foundation, and it certainly does deserve our support. The issue at stake is whether this should be financed through a compulsory portion of our dues structure. I believe it should not.

Speaker Callan: Are you ready for the question on the proposed amendment which would raise the dues $15 and earmark $5 of that for the CES Foundation?

Doctor Drew: Do you include the word "voluntary"?

Speaker Callan: No. It would raise the dues $15. We are voting on the amendment to raise the dues $15, earmarking $5 to the CES Foundation.

Doctor Bernhart: Repeat the amendment.

Speaker Callan: The regular membership dues would be increased by $15 per year, and $5 of that would be earmarked for the CES Foundation.

Doctor Bernhart: What is the dues now?

Speaker Callan: It is $90 now, I believe. It would be $105. Do you all understand the proposed amendment? Are you ready for the question? All those in favor of raising the dues $15, earmarking $5 of it to the CES Foundation, signify by saying "aye"; all those opposed, "no". The "noes" have it and the amendment is lost.

We will now turn to the main motion. Is there further discussion of the motion that the regular membership dues be increased by $10 per year and that an additional voluntary $5 be billed for the CES Foundation? Any further discussion?

Doctor Kovacic: May we ask why the dues are raised $10?

Doctor Nereim: The dues are raised $10 because they haven't been raised for a while [laughter] and the cost of operating this Society has increased and no further income has been added. It was felt by the Council that we should have some more money with which to operate.

Doctor Collentine: As a member of the Reference Committee I don't like to hear the question answered as lightly as that. It is time for us to face the facts, gentlemen.

We are presented with a budget for some $410,000 and an estimated income of $385,000. We need $30,000 more to accomplish what we have directed the staff to do this year and next year, over and above what we did last year. It is time for us to decide whether we are going to recognize that if we don't raise the dues we have a fixed income, and that if we have a fixed income we can't add on projects that cost money.

So, we are putting the cart before the horse when we say to the Reference Committee, "Here is a budget for the projects that have been approved by the Council and accepted by the House of Delegates, and they cost $30,000 more than what we have," and then ask the Reference Committee to not recommend raising the dues.

I am in favor of each one of us in his heart adopting a policy that we are going somehow to try to keep the dues as they are and to curtail our projects and scrutinize them more severely so that we won't have to increase the dues.

Dr. Howard Mauthe (Section on Radiology): I would like to inquire of Doctor Collentine whether any of the projects of which he is speaking are charitable in nature.

Doctor Collentine: In answer to the question, I would say No. I think if we decide we are going to have a big splash in 1966 for our 125th anniversary, that will cost money. If we decide that we are going to have a fairly liberal expense allowance for delegates and alternates to the AMA conventions; and if we are going to continue the public information projects we have; if we are going to have Work Weeks of Health; if we are going to have legislative counsel—call it lobbying if you want to—and if we aren't going to scrutinize every dollar that is spent, if you don't call that charity, the answer is No.

Doctor Mauthe: I would like to comment that while I am not opposed to any of the projects Doctor Collentine has mentioned, I personally feel that the projects of the CES Foundation are of infinitely greater importance.

Doctor Bernhart: A lot of these projects that have been introduced and that are in effect as of now cost a lot of money. The budget has been scrutinized by the Finance Committee and the Council last night, and we feel we need more money. You men in your own households have been spending more money to live, with the dollar value of the economy what it is today. We have got to go with the times. I am very much in favor of a dues increase of $10, even though connected with it is an extra $5.

Doctor Kovacic: I didn't throw this in as sand in the ointment; I just wanted to know what the logic is of the Reference Committee. I am entirely in favor of progress in the Society, and I am willing to go along with the dues increase.

Dr. E. P. Rohde (Trempealeau–Jackson–Buffalo): May I make a suggestion to every member present here, that they take up this supplemental report of the Council marked (E) and not just throw it in with a lot of other papers and forget about it, but take it back to your membership and pass it around and see that the members know where their money is going.

We always hear, "We never know where the money is going, and it's costing too much." Admittedly there are a lot of rounded figures, but at least this supplemental report gives some idea of where the money is going.

One group says, "If I go back and tell my membership that we are raising the dues again, they are going to climb all over me." Why are they going to climb all over you? Simply because they do not understand what the money is being spent for. They want all the services of a medical society, and all the protection and all the lobbying, and they always say, "Why doesn't the Society do this, that and the other thing?" They want it but they aren't willing to pay for it.

Doctor Drew: Is the $40,000 that was discussed this morning included in the budget set up for next year?

Speaker Callan: I am unable to answer that. Doctor Nereim, do you have the answer?

Doctor Nereim: I am not sure.

Speaker Callan: What $40,000, Doctor Drew?

Doctor Drew: The sum of $40,000 was mentioned this morning as being set aside for the CES Foundation.

Secretary Crownhart: We interested a corporation in a donation of $40,000 to the Foundation. It is a donation from outside sources which will be paid over a period of three years.

Doctor Drew: It has nothing to do with our budget?

Secretary Crownhart: That's right.

Speaker Callan: Any further discussion on this motion concerning the dues structure? The vote will be on the recommendation that the regular membership dues be increased by $10 per year, and that an additional voluntary $5 be billed for the CES Foundation. Are you all clear on that?

[Motion carried.]

Doctor Nereim: I now move adoption of this report as a whole.

[Motion seconded and carried.]

Dr. Carlson, do you have a supplemental report of the Credentials Committee?

SUPPLEMENTAL REPORT OF CREDENTIALS COMMITTEE

Doctor Carlson: In addition to those delegates already registered and reported by the Committee on Credentials, 6 delegates have registered and are entitled to vote.

I move that this attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 57, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

Speaker Callan: Is there any new business? Mr. Secretary, have you any announcements to make? If not, the Speaker wishes to thank the House of Delegates, its reference committees, the staff of the Medical Society, and all the delegates and alternates for once again giving excellent efforts to make this interim session a success.

A motion is in order for adjournment sine die.

Doctor Drew: I so move.

[Motion seconded and carried.]

[House of Delegates adjourned sine die at 8:55 p.m.]

■ ATTENDANCE AT HOUSE OF DELEGATES

	Sessions 1	Sessions 2
SOCIETY:		
Ashland—Bayfield—Iron		
C. A. Grand, Ashland	x	x
J. M. Jauquet, Ashland	o	o
Barron—Washburn—Sawyer—Burnett		
C. J. Strang, Barron	x	x
Robert Anderson, Cumberland	o	o
Brown		
B. P. Waldkirch, De Pere	x	x
Donel Sullivan, Green Bay	o	o
F. D. Cook, Green Bay	o	o
M. D. Blackburn, Jr., Green Bay	x	x
Calumet		
E. W. Humke, Chilton	o	o
A. C. Engel, New Holstein	o	o
Chippewa		
M. W. Asplund, Bloomer	x	o
J. J. Sazama, Chippewa Falls	o	o
Clark		
M. V. Overman, Neillsville	o	o
R. L. Hansen, Colby	o	o
Columbia—Marquette—Adams		
R. R. Rueckert, Portage	o	o
R. T. Cooney, Portage	x	x
Crawford		
M. S. Garrity, Prairie du Chien	o	o
T. F. Farrell, Prairie du Chien	o	o
Dane		
R. N. Allin, Madison	o	x
A. J. Richtsmeier, Madison	o	o
Robert L. Beilman, Madison	x	o
F. D. Bernard, Madison	o	o
N. M. Clausen, Madison	x	x
R. P. Sinaiko, Madison	o	o
T. J. Nereim, Madison	x	x
K. L. Siebecker, Madison	o	o
W. T. Russell, Sun Prairie	x	x
C. K. Kincaid, Madison	o	o
A. P. Schoenenberger, Madison	x	o
G. E. Oosterhous, Madison	x	x
R. A. Straughn, Madison	x	x
G. J. Derus, Madison	x	o
H. M. Suckle, Madison	x	x
P. G. Piper, Madison	o	o
Dodge		
L. W. Schrank, Waupun	x	x
R. E. Urbanek, Beaver Dam	x	o
Door—Kewaunee		
W. G. Sheets, Sturgeon Bay	x	x
Patricia Lanier	o	o
Douglas		
C. J. Picard, Superior	x	x
R. P. Fruehauf, Superior	o	o

First name is delegate, indented name is alternate. x—present, o—absent.

	Sessions 1	Sessions 2
Eau Claire—Dunn—Pepin		
D. R. Griffith, Eau Claire	x	x
G. G. Giffen, Eau Claire	o	o
A. A. Drescher, Menomonie	o	o
W. R. Manz, Eau Claire	x	x
Fond du Lac		
D. J. Twohig, Jr., Fond du Lac	x	x
W. E. Myers, Fond du Lac	o	o
Forest		
E. F. Castaldo, Laona	o	o
B. S. Rathert, Crandon	o	o
Grant		
C. L. Steidinger, Platteville	x	x
H. W. Carey, Lancaster	x	o
Green		
R. G. Zach, Monroe	o	o
W. J. Staab, Jr., Monroe	o	o
Green Lake—Waushara		
David J. Sievers, Berlin	x	x
Russell Darby, Wautoma	o	o
Iowa		
W. D. Hamlin, Mineral Point	x	x
S. B. Marshall, Hollendale	o	o
Jefferson		
J. J. Voytek, Fort Atkinson	o	o
R. R. Liebenow, Lake Mills	o	o
Juneau		
M. S. Tverberg, Mauston	o	o
Jack Strong, Mauston	o	o
Kenosha		
Richard Powell, Kenosha	x	x
Walter Rattan, Kenosha	o	o
Louis Olsman, Kenosha	x	x
La Crosse		
G. B. Murphy, Jr., La Crosse	x	x
Mark O'Meara, La Crosse	o	o
D. L. Morris, West Salem	x	x
Frederick H. Wolf, La Crosse	o	o
Lafayette		
N. A. McGreane, Darlington	o	o
Lyle L. Olson, Darlington	o	o
Langlade		
Dee W. Dailey, Elcho	o	o
John E. McKenna, Antigo	o	o
Lincoln		
R. J. Henderson, Tomahawk	x	x
J. F. Bigalow, Merrill	x	x
Manitowoc		
T. H. Rees, Manitowoc	o	o
W. F. Smejkal, Manitowoc	o	o
Marathon		
E. P. Ludwig, Wausau	o	o
A. H. Stahmer, Wausau	o	o
Marinette—Florence		
J. W. Boren, Jr., Marinette	x	x
C. E. Koepp, Marinette	o	o
Milwaukee		
V. L. Baker, Milwaukee	o	o
R. T. Sproule, Milwaukee	o	o
N. G. Bauch, Milwaukee	o	o
W. L. Coffey, Jr., Milwaukee	o	o
E. L. Bernhart, Milwaukee	x	x
L. E. Rothman, Milwaukee	o	o
D. J. Carlson, Milwaukee	x	x
R. B. Pittelkow, Milwaukee	o	o
J. F. Cary, Milwaukee	o	o
R. A. Nimz, Milwaukee	o	o
G. E. Collentine, Jr., Milwaukee	x	x
John Bareta, Milwaukee	o	o
E. G. Collins, West Allis	x	x
F. J. Millen, Milwaukee	o	o
W. J. Connen, Milwaukee	x	x
E. J. Schmidt, Wauwatosa	o	o
F. E. Drew, Milwaukee	x	x
P. G. LaBissoniere, Milwaukee	o	o
Edgar End, Milwaukee	o	o
G. W. Dean, Milwaukee	x	x
Norbert Enzer, Milwaukee	o	o
R. H. Lillie, Milwaukee	o	o
G. W. Hilliard, Jr., Milwaukee	x	x
T. F. Jennings, Milwaukee	o	o
G. S. Kilkenny, Milwaukee	x	x
R. J. Snartemo, Milwaukee	o	o
H. M. Klopf, Milwaukee	o	o
B. J. Peters, Milwaukee	o	o
H. J. Lee, Milwaukee	o	o
W. H. Frackelton, Milwaukee	o	o
George Murphy, South Milwaukee	o	o
R. H. Frederick, West Allis	o	o
R. F. Purtell, Milwaukee	o	o
Roger Laubenheimer, Milwaukee	o	o
Ann Roethke, Milwaukee	o	o
R. R. Watson, Milwaukee	o	o
F. A. Ross, Milwaukee	x	x
T. J. Cox, Milwaukee	o	o
D. M. Ruch, Milwaukee	x	x
K. A. Liefert, Wauwatosa	o	o
A. J. Sanfelippo, Milwaukee	x	x
J. R. O'Connell, Milwaukee	o	o
C. M. Schroeder, Milwaukee	o	o
K. E. Sauter, Milwaukee	o	o
H. F. Twelmeyer, Wauwatosa	x	x
D. W. Calvy, Milwaukee	o	o
L. R. Weinshel, Milwaukee	o	o
W. S. Polacheck, Milwaukee	o	o
E. D. Wilkinson, West Allis	x	x
Rex Ruppa, Milwaukee	o	o
S. E. Zawodyn, Milwaukee	o	o
J. R. Evrard, Milwaukee	o	o
Monroe		
C. B. Koch, New Lisbon	o	o
R. G. Konicek, Tomah	o	o
Oconto		
G. R. Sandgren, Suring	o	o
J. R. Culver, Oconto Falls	o	o
Oneida—Vilas		
Marvin Wright, Rhinelander	o	o
Henry S. Ashe, Minocqua	o	o
Outagamie		
G. A. Behnke, Kaukauna	x	x
J. H. Russell, Appleton	o	o
W. H. Hale, Appleton	o	o
J. G. Bergwall, Hortonville	x	x
Ozaukee		
J. F. Walsh, Port Washington	x	x
R. H. Dorr, Belgium	o	o
Pierce—St. Croix		
P. H. Gutzler, River Falls	x	x
C. A. Olson, Baldwin	x	x
Polk		
L. O. Simenstad, Osceola	x	x
R. M. Moore, Frederic	o	o
Portage		
F. E. Gehin, Stevens Point	o	o
A. J. Sowka, Stevens Point	o	o
Price—Taylor		
J. D. Leahy, Park Falls	o	o
J. L. Murphy, Park Falls	o	o

	Sessions 1	Sessions 2
Racine		
V. J. Burch, Racine	x	o
Richard Minton, Racine	o	o
Wm. Henken, Racine	x	o
R. B. Leitschuh, Racine	o	o
Richland		
R. E. Housner, Richland Center	o	o
Dale R. Shampo, Richland Center	x	o
Rock		
M. F. Purdy, Janesville	x	x
C. M. Carney, Beloit	o	o
D. M. Clark, Beloit	o	o
J. R. Schroder, Janesville	o	o
Rusk		
H. F. Pagel, Ladysmith	o	o
M. L. Whalen, Bruce	o	o
Sauk		
E. V. Stadel, Reedsburg	o	o
J. A. Tibbitts, Reedsburg	x	o
Shawano		
H. F. Laufenburg, Shawano	o	o
D. A. Jeffries, Shawano	o	o
Sheboygan		
Joseph F. Kovacic, Sheboygan	x	x
William W. Moir, Sheboygan	o	o
Trempealeau—Jackson—Buffalo		
E. P. Rohde, Galesville	x	x
W. E. Wright, Mondovi	o	o
Vernon		
Robert A. Starr, Viroqua	x	x
Thomas Boston, Hillsboro	o	o
Walworth		
E. D. Sorenson, Elkhorn	x	o
R. S. Galgano, Delavan	o	o
Washington		
E. C. Quackenbush, Hartford	x	x
W. A. Nielsen, West Bend	o	o
Waukesha		
James V. Bolger, Jr., Waukesha	o	o
Clarence Samuelson, Hartland	o	o
Robert Monk, Waukesha	o	o
Thomas Dugan, Waukesha	x	o
Waupaca		
Kenneth L. Haman, Waupaca	o	o
Jerry Salan, Waupaca	o	o
Winnebago		
S. J. Graiewski, Oshkosh	o	o
H. J. Colgan, Neenah	x	x
John Nebel, Menasha	o	o
Wood		
E. C. Glenn, Wisconsin Rapids	o	o
W. B. Larkin, Marshfield	o	o
Russell F. Lewis, Marshfield	x	x
John E. Thompson, Nekoosa	o	o
SECTION:		
Dermatology		
Joel Taxman, Milwaukee	x	x
Thomas S. Kemp, Madison	o	o
General Practice		
R. R. Richards, Eau Claire	x	x
J. A. Kelble, Milwaukee	o	o
Internal Medicine		
L. J. Kurten, Racine	o	o
R. L. Gilbert, La Crosse	o	o
Neurology—Psychiatry		
R. E. O'Connor, Madison	o	o
Edward E. Houfek, Sheboygan	o	o
Obstetrics—Gynecology		
Donald O. Price, Madison	x	x
Leo Grinney, Racine	o	o
Ophthalmology—Otolaryngology		
Frank Treskow, Milwaukee	x	x
John Doolittle, Madison	o	o
Orthopedics		
J. O. D. McCabe, Milwaukee	o	o
John Van Driest, Sheboygan	o	o
Pathology		
J. L. Tercsi, Milwaukee	x	o
L. W. Kleppe, Beloit	o	o
Pediatrics		
Richard L. Myers, Green Bay	o	o
Edward Zupanc, Monroe	o	o
Public Health		
E. E. Bertolaet, Milwaukee	o	o
G. M. Shinners, Green Bay	x	x
Radiology		
Howard Mauthe, Racine	o	x
L. E. Jones, Racine	o	o
Surgery		
J. A. Killins, Green Bay	x	o
A. G. Martin, Milwaukee	o	o
Urology		
F. M. Hilpert, Racine	x	o
A. J. Jacobsen, Racine	o	o
Anesthesiology		
Harry Thimke, Eau Claire	o	o
David Noll, Madison	o	o

NEW NAME, NEW GOALS SET BY ARTHRITIS FOUNDATION

The Arthritis and Rheumatism Foundation, now the sole voluntary health agency in the field of arthritis, on October 6 adopted a new name, the Arthritis Foundation, and doubled its goals for dollars and service to meet the needs of what its top officials called "an emergency the public can no longer ignore."

Speaking for more than 200 chapter representatives and volunteers who met for the Foundation's Annual Meeting at the Hotel Biltmore in New York in early October, chairman of the board, Floyd B. Odlum and newly appointed president Dr. William S. Clark outlined a new national program which includes a campaign goal of $10,000,000 for 1965 and a drive to increase the number of Foundation chapters from 78 to 130.

WANTED: GENERAL PRACTITIONER to serve primarily as a surgical assistant in 17-man Wisconsin group. This is an opportunity to gain surgical experience under qualified surgeons. Starting salary $10,000 per annum. Contact Dept. 117 in care of the Journal. p8–12

POSITION WANTED: GENERAL SURGEON, experienced with training in thoracic and pediatric surgery as well as broad medical experience, wishes to join large active clinic or group in Milwaukee. Contact Dept. 118 in care of the Journal. m8tfn

FOR SALE: Well equipped and good business of retiring general practitioner. Reason: ill health. Good hospital facilities. Easy terms. Available at once. Walter J. Jones, M.D., 2401 Main St., La Crosse, Wis., phone 4–1550. m10tfn

PHYSICIAN'S OFFICE FOR RENT: Excellent location, new building, air conditioned. Highway 100, Hales Corners, Milwaukee county, Wis. Private waiting room, consultation room, two examining rooms, and laboratory. Apply R. C. Wolf, M.D., 5513 S. 110th St., Hales Corners, Wis. 53130. m10tfn

FOR SALE: Established general surgical specialty practice in Wisconsin's northwoods with modern completely equipped office and hospital. Owner wishes to engage in academic postgraduate work. Terms arranged if desired. Contact Dept. 131 in care of the Journal. m11tfn

E.E.N.T. MAN CAPABLE OF EYE SURGERY wanted by the Palm Springs Medical Clinic located in Palm Springs, Calif., where summer spends the winter. Ideal working conditions in new clinic building. International clientele. Liberal summer vacation. Financial arrangements open to discussion. Contact James B. Oliver, M.D., 1695 North Sunrise, Palm Springs. Phone 324–1531. 10–12

BUILDING FOR SALE: Two-story, prestressed concrete block building at 1905 Monroe Street, Madison, available Jan. 1. App. 3,000 sq. ft., 5 years old, central air conditioning. Contains physicians' suite of offices (equipment and furniture also for sale). Dentist now occupies part. Rental income on second floor. Complete financing available. Parking facilities in rear of building. Present physician leaving for specialty training. Call night or day: Kenneth Brost, Hoff & Lem, Inc., 202 Executive Bldg. (Hilldale) Madison; phone home: 255–3194, office: 238–8261. 11–1

PROFESSIONAL AIR AMBULANCE SERVICE: Multi or single engine aircraft. All weather and night flight capability, anywhere in the U. S. Oxygen, respirator, aspirator, nursing service, all medications. Also full time M.D. Board anesthesiologist providing all medical care in flight available on request. MIDWEST AIR TRANSPORT'S Operations Office, Municipal Airport, Waterloo, Iowa, phone 319–2331083. 10–9

Medical Bowling Tournament

Sat.–Sun., March 13–14
Marshfield, Wisconsin

- Men's Singles
- Women's Singles
- Men's Doubles
- Women's Doubles
- Mixed Doubles
- Team Events

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A Monthly Journal of Medicine and Surgery

with organizational coverage of the medicolegal, socio-economic, ancillary, and public relations aspects in the practice of medicine

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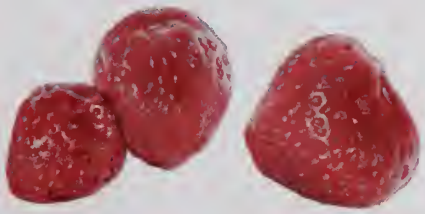

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In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

the wisconsin medical journal

official publication of

THE STATE MEDICAL SOCIETY OF WISCONSIN

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AMYTAL TAKES THE EDGE OFF DAYTIME ANXIETY AND TENSION

Amytal is a moderately long-acting barbiturate that takes the edge off daytime anxiety and tension without significant change in mood and attitude. Since Amytal is metabolized in the liver within twenty-eight hours, overlapping of effect is minimized, and renal damage does not constitute an absolute contraindication to the drug.

Side-Effects: Idiosyncrasy or allergic reactions to the barbiturates may occur.

Precautions and Contraindications: Amytal should be used with caution in patients with decreased liver function, since a prolongation of effect may occur. Administration in the presence of uncontrolled pain may produce excitement. Warning—May be habit-forming.

Dosage: Doses should be individualized for each patient. The usual adult sedative dosage ranges from 30 mg. (1/2 grain) to 50 mg. (3/4 grain) two or three times daily.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis 6, Indiana.

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DEHYDROCHOLIC ACID.....250 mg (3¾ gr)
to produce large volume of watery bile, hydrate the bowel contents and gently stimulate the intestinal mucosa

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to reduce smooth-muscle hypertonus

Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

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When psychic tension mounts

Valium® (diazepam)

useful in alleviating

- psychic tension mixed with depressive symptoms
- psychic tension in the common psychoneuroses
- psychic tension intensified by concomitant somatic disorders

How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psychotic patients, and for this reason should not be employed in lieu of appropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.,* convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

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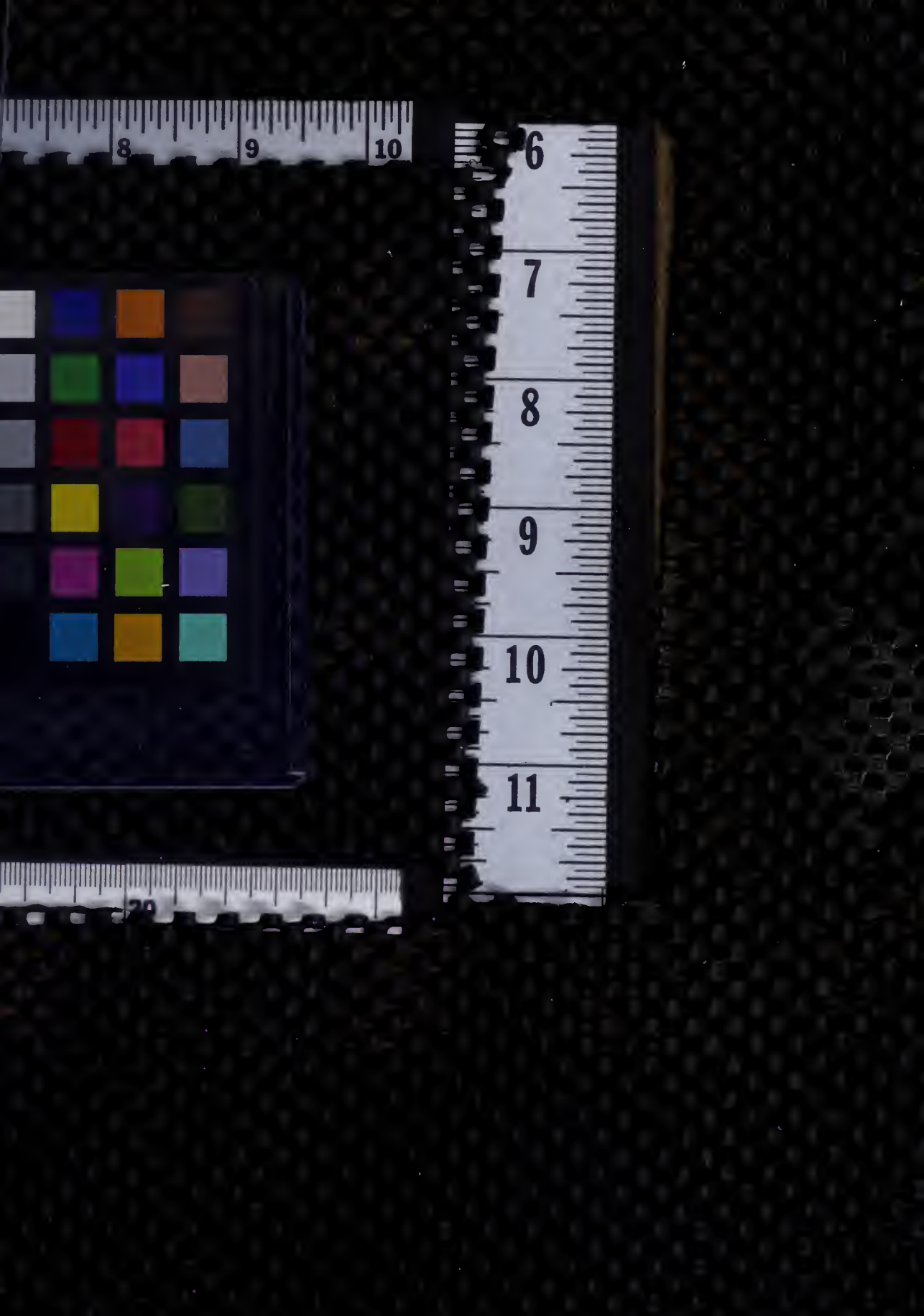
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